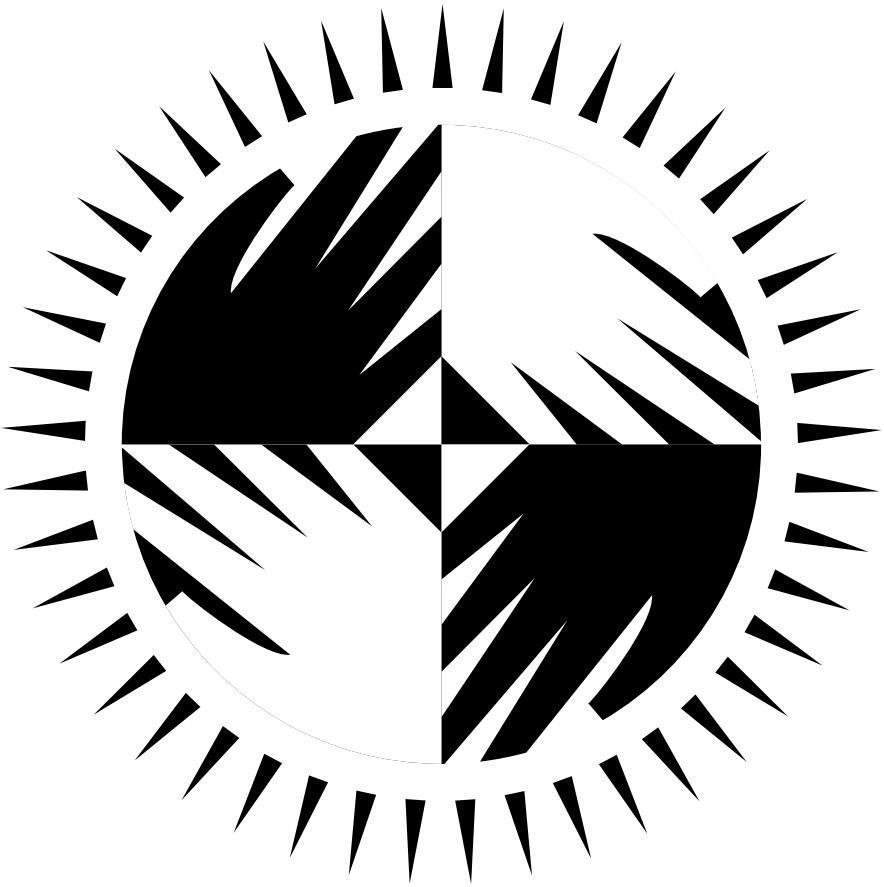

HIV/STD ANNUAL REPORT 1997

Texas Department of Health
Bureau of HIV & STD Prevention

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ACKNOWLEDGMENTS

Thanks to the following staff of the Bureau of HIV and STD Prevention, Texas Department of Health, for contributing to this report: Susan Aulds; and in alphabetical order, John Allen; Marcia Becker; Greg Beets; Doug Hamaker, Jim Koch, Ph.D.; Jim Lee; Sundee McKnight; Linda Moore, M.S., R.N.; Beverly Nolt; and Bea Sneed.

I. EXECUTIVE SUMMARY

From the beginning of the Human Immunodeficiency Virus (HIV) epidemic in the early 1980s to the end of 1997, over 44,800 acquired immunodeficiency syndrome (AIDS) cases have been reported in Texas. A total of 85,660 STD cases were reported in Texas in 1997. While reported cases of syphilis declined, chlamydia, gonorrhea and pelvic inflammatory disease (PID) increased 18%, 16% and 35%, respectively. Young people aged 15 to 19 years accounted for almost 60% of all reported STDs, with adolescents aged 15 to 19 accounting for almost 30%.

The total operating budget for HIV and STD programs for fiscal year (FY) 1997 was $66,350,806. The Bureau of HIV and STD Prevention distributed $33,607,052 to regional and local health departments and community based organizations throughout the state in 1997. Over $21 million were spent on providing HIV and STD medications to Texas residents in 1997.

HIV prevention efforts focused on the high risk target populations identified through community planning activities. A total of 138,161 HIV tests were provided at counseling and testing sites throughout Texas in 1997, resulting in the identification of 1,515 HIV positive individuals. Health education and risk reduction messages were delivered by peer educators in over 213,000 contacts with members of high risk target populations across the state. Almost 16,000 persons with AIDS and HIV infection received basic HIV-related social and medical services in Texas in 1997. Housing and utility assistance were provided to 1,940 persons with HIV and AIDS in Texas.

Prevention activities provided by STD programs resulted in an estimated $30,000,000 savings in medical costs related to STDs and $18,000,000 savings related to HIV. Sexually Transmitted Disease (STD) clinics across Texas reported more than 119,000 clinic visits in 1997. Disease Intervention Specialists (DIS) interviewed and managed 2,903 reported syphilis cases in Texas in 1997. A total of 1,293 contacts for syphilis were referred by DIS and provided preventative therapy, resulting in the prevention of 388 cases of syphilis.

In 1997, over 600 HIV counselors were trained in 68 courses at locations across Texas. The Texas HIV/STD InfoLine, which provides a telephone link between the people of Texas and the Texas Department of Health (TDH), received over 23,000 calls in 1997. The 1997 Texas HIV/STD Conference in Austin on June 29 - July 3, 1997, attracted over 1,100 HIV/STD health professionals.

The Texas HIV Medication Program distributed over $17 million dollars of antiretrovirals and other prophylactic medications in 1997, a three-fold increase over 1996 levels. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Medication Reimbursement Initiative (MRI) paid deductibles and co-insurance payments in the amount of $19,975. This support allowed MRI applicants to access approximately $325,550 of HIV-related medication. The Texas STD Medication Program distributed $561,538 in STD medications and related supplies to 52 sites statewide in 1997.

II. BUREAU OF HIV AND STD PREVENTION

The Texas Department of Health (TDH), Bureau of HIV and STD Prevention consists of three Divisions: the HIV/STD Health Resources Division; the Epidemiology Division; and the Pharmacy Division (Figure 1). The HIV/STD Health Resources Division is responsible for policy and planning, field operations, training, and grants and contract development. The Epidemiology Division includes surveillance, epidemiologic assessment, research and evaluation, data management and other technical functions. The Pharmacy Division supports the HIV/STD Medication Program and other medication programs across the department.

Mission Statement

Our mission is to prevent, treat, and/or control the spread of HIV, STD, and other communicable diseases to protect the health of the citizens of Texas. In keeping with this mission, we procure, allocate, and manage fiscal and human resources so that we may:

Provide HIV/STD education and information,
Collect, interpret, and distribute data relating to HIV and STD,
Provide guidance to those who oversee, plan for, or provide HIV and STD services, and
Provide medication and supplies to prevent, manage, and treat communicable diseases.

In pursuit of this mission, we will make every effort to assure that the citizens of Texas receive quality services.

The Bureau of HIV and STD Prevention (Bureau) is dedicated to preventing the spread of HIV and other STDs and minimizing complications and costs. This is achieved primarily through education, prevention counseling screening and testing, partner elicitation and notification, and the provision of medical and social services. The TDH provides some of these services directly, but most often through contracts with local agencies to provide community-based services when appropriate. This report documents many of the activities and accomplishments of the Bureau in 1997 and provides an epidemiologic assessment of HIV, AIDS, and STDs in Texas. Because the Pharmacy Division primarily serves other programs it is not discussed in this report.

The IOM Report and Development of a Strategic Plan

In late1996 the Institute of Medicine (IOM)[1] issued a comprehensive study of STDs in the United States, entitled *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. In the study, the IOM established that STDs are of epidemic proportions in the U.S. and that their annual cost to our economy is

[1] The Institute was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public.

more than $17 billion. They found that:

- Five of the top ten most frequently reported diseases in the U.S. during 1995 were STDs, which accounted for 87% of all top ten cases reported that year.
- The rates of curable STDs in the U.S. are the highest in the developed world.
- Adolescents and young adults are at greatest risk of acquiring an STD.
- STDs have a disproportionate impact on women in terms of life-threatening and devastating outcomes.
- Several classes of STDs increase both the infectivity of and susceptibility to HIV, and prevention and treatment of those STDs could greatly reduce the number of HIV infections.

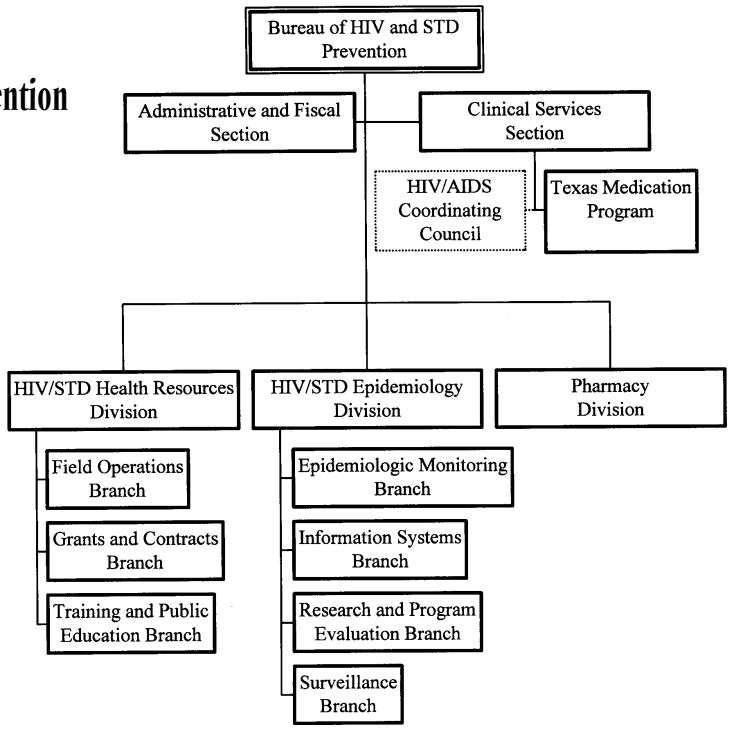
Many of the issues and recommendations from the IOM report were the focus of discussion by the Bureau's Strategic Planning Steering Committee (SPSC), a group that was formed in late-1996 to develop a strategic plan for the succeeding three-year period that would set priorities and guide the Bureau's response in meeting the challenges of a continually changing environment.

During 1997, the twenty-four member SPSC, composed of representatives from the Central Office, regional staff and external customers, developed criteria for the selection of strategies and identified the following six unique issues to be addressed by the Plan:

- The capacity of contractors to perform at consistent levels.
- Early access to quality care.
- Integration of HIV and STD prevention and services.
- Increased emphasis on STD prevention and treatment.
- Increasing the comprehensiveness and utilization of HIV/STD surveillance and data.
- Increasing the capacity of TDH staff to excel at its tasks and effectively respond to change.

Strategy Work groups were created to address each issue, with SPSC members taking on the responsibility for recruiting a mix of internal and external customers to lend expertise to strategy development. The Strategic Plan, due for completion in early-1998, will be monitored on an ongoing basis by the SPSC in order to revisit the strategies and make appropriate changes in response to major funding and legislative and policy changes.

Figure 1
Bureau of HIV and STD Prevention

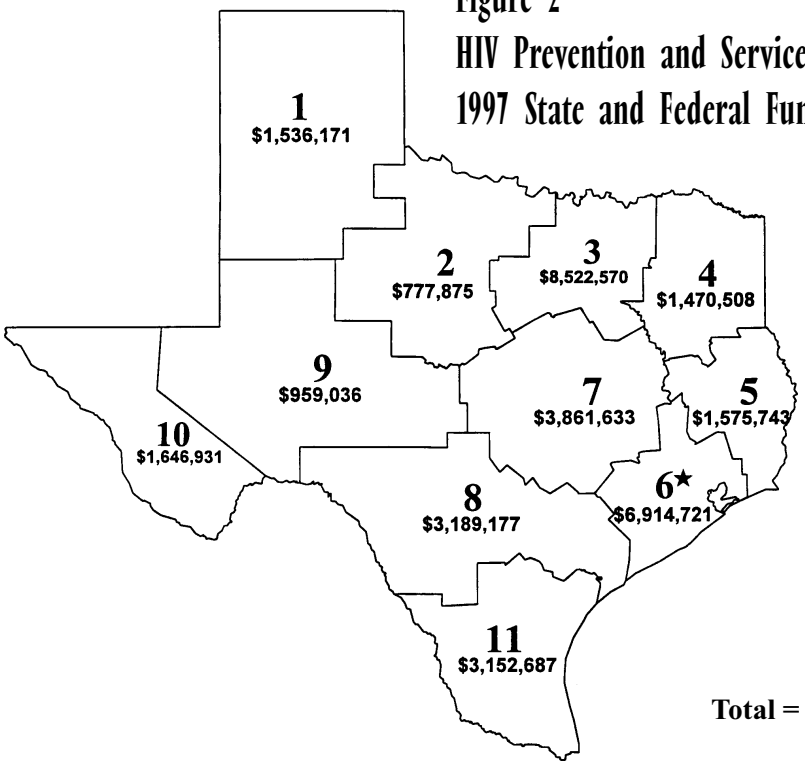


III. FUNDING - FY 1997

The total operating budget for HIV and STD programs for FY 1997 was $66,350,806. Slightly over two-thirds of the budget ($44,583,492) was provided by federal HIV and STD grants, almost one-third ($21,767,314) by State funds. The HIV and STD funds were allocated as follows: $18,152,733 (27%) for prevention; $22,280,914 (34%) for services; $21,453,313 (32%) for medication; and $4,463,845 (7%) for surveillance. The 1997 budget represented a more than 33% increase over the 1996 budget, most of the increase being applied to the medication program for purchase and distribution of the triple combination protease inhibitors.

Over $33.6 million, more than 83%, of the total HIV and STD prevention and services resources were distributed to regional and local health departments or other contracted community based agencies through prevention and services contracts (See Figure 2). Over 32% of the total HIV and STD resources were spent providing HIV and STD medications in Texas. Other Bureau expenditures included training and public education, regional and central office administrative costs, laboratory costs, travel, supplies and equipment, and public health promotion. Administration encompasses activities such as program planning and development, quality control and technical assistance to contractors, contract monitoring and grants management, and related programmatic and support services. The Bureau also supports the Funding Information Center (FIC) with HIV funds. The FIC researches and disseminates HIV/AIDS-related funding information to the Texas public.

Figure 2
HIV Prevention and Services Contracts Awarded by PHR
1997 State and Federal Funds



Total = $33,607,052

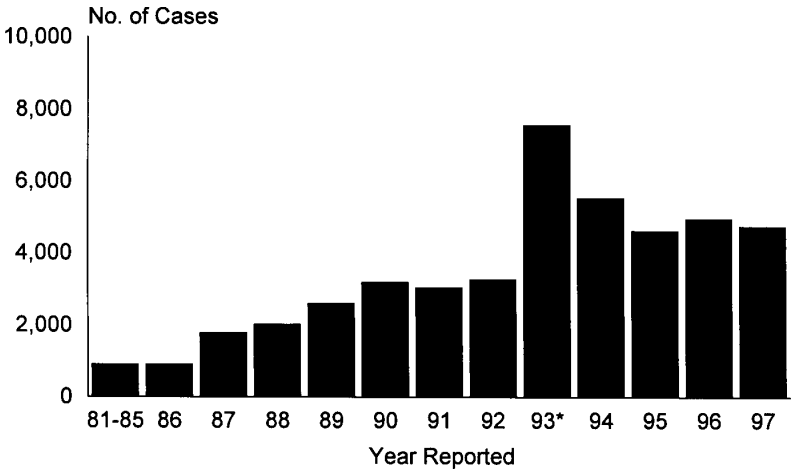
IV.HIV, AIDS & STDS IN TEXAS
EPIDEMIOLOGIC ASSESSMENT

HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the late stage of infection with the human immunodeficiency virus (HIV) and is characterized by severe immunosuppression and co-infection with other opportunistic agents. HIV specifically infects and depletes a subgroup of white blood cells (lymphocytes) called helper T-lymphocytes. These cells are also called CD4+T-cells, which is a term based on laboratory tests that identify these cells by the presence of a specific cell surface marker, CD4. The decline in the number of CD4+T-cells is an indicator of HIV disease progression.

The CD4+T-cell count became an important part of the AIDS surveillance case definition that the Centers for Disease Control and Prevention (CDC) revised in 1993. The new case definition includes all HIV-infected persons with CD4+T-cell counts fewer than 200 per microliter of blood, or less than 14% of total lymphocytes. Before this change, the AIDS case definition relied on a confirmed positive HIV test and the identification of one of several indicator diseases that commonly occur among immunocompromised HIV-infected patients.

Figure 3
AIDS Cases by Year of Report, 1981 - 1997
44,865 Cumulative Cases Reported Through 12/31/97



Identifying trends in the AIDS epidemic in recent years has been difficult because of the change in the AIDS case definition. The inclusion of the CD4+T-cell count criteria caused a marked increase in cases reported in 1993. The lower numbers from 1994 to 1996, after the peak in 1993, may not be a true decline in AIDS morbidity (Figure 3). Rather, a tremendous number of cases meeting the new definition artificially inflated the 1993 count. Many HIV-infected persons met the new criteria for AIDS months or years earlier than they would have met the previous criteria that relied on the development of symptomatic disease. A high percentage of recent AIDS cases are now reported based on CD4+T-cell counts rather than AIDS indicator diseases (63% of those reported in 1997).

Currently Texas, like many states and cities throughout the world, is experiencing a decline in AIDS cases. Texas AIDS data is reported in terms of the year the case was reported to TDH, not the year the person was diagnosed with AIDS. Although from 1996 to 1997 the number of AIDS reports decreased only slightly, preliminary analyses indicate that around 10% fewer people were diagnosed with AIDS in 1997. The triple combination therapies halt, at least temporarily, the decline of CD4+ T lymphocyte counts in people with HIV, so fewer are likely to be counted as AIDS cases in the near future.

Along with the decline in AIDS cases, the current trend extends to a decline in AIDS deaths. The decrease in AIDS deaths, like the decrease in progression to AIDS, has been generally attributed to the use of triple drug therapy which delays the progression from HIV infection to AIDS. Although treatment with the triple drug combination is receiving the credit for the decline, other preventive strategies have also entered into the equation: HIV positive individuals are being treated at earlier stages, a variety of therapeutic interventions as prophylaxis for secondary infection are available, specific targeting to high-risk groups for early testing and preventive education has increased, and the wider variety of medications to choose from have all created a more favorable prevention strategy. With the advent of new drug therapies and HIV measurement methods, guidelines for treatment have shifted from treatment of symptomatic patients to early treatment of asymptomatic HIV-positive individuals. These advances increase the importance of education for persons at risk so that they seek HIV testing and access appropriate treatment in a timely fashion.

In Texas, AIDS deaths declined 45% during the first 6 months of 1997 compared with the first six months of 1996. This decline is in line with the findings nationwide and as announced by CDC. The decline in AIDS deaths is demonstrable across all races. Among men, the greatest decline in deaths has been for African Americans, followed by Whites and Hispanics. Among women, the greatest decline in deaths has been among Hispanics, followed by African Americans and Whites (Table 1).

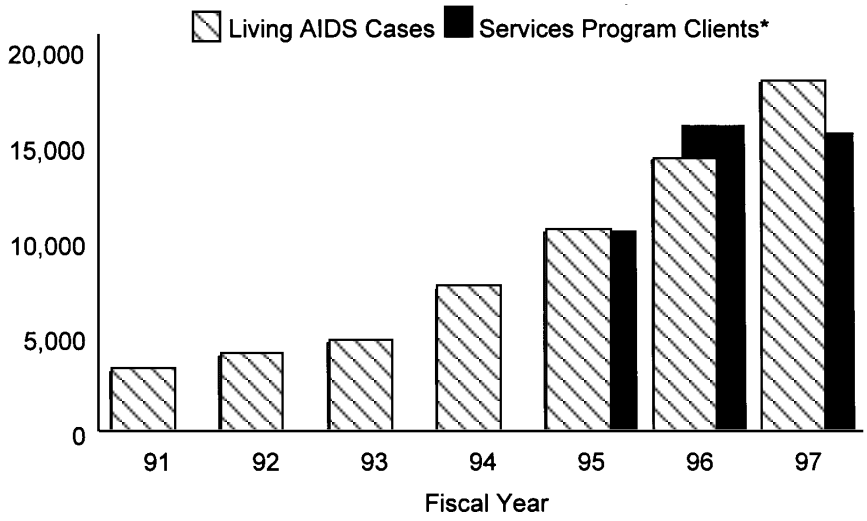
By the end of 1997, 44,865 AIDS cases had been reported, in Texas, since the epidemic began in the early 1980's. Texas ranked 4th highest in the U.S., with 4,720 AIDS cases reported in 1997 (Figure 3). The overall rate was 24.4 AIDS cases per 100,000 population. In 1996, for the first time since 1989, AIDS dropped to the second leading cause of death in Texas for men 25 to 44 years old. AIDS has remained the third leading cause of death for Texas women 25 to 34 years of age during both 1995 and 1996.

Table 1
Texas AIDS Deaths Comparison by Race and Sex

	January through 1996-Deaths	January through June 1997-Deaths	% Difference In Deaths
Males			
White	532	282	-47
African American	309	155	-50
Hispanic	210	130	-38
All Others	6	5	-17
Females			
White	44	33	-25
African American	67	45	-33
Hispanic	29	8	-72
All Others	0	0	0
Totals	**1197**	**658**	**-45**

The number of Texans living with AIDS as of the end of 1997, (18,591), has more than doubled in the past four years. New drug therapies account in part for this increase. However, these new therapies also mask the full impact of HIV infections on health care services if only the number of AIDS cases are considered. New drug treatments now available to HIV-infected patients delay the decline of CD4+T-cell counts and the progression to an AIDS-defining condition for these individuals. People with AIDS are living longer and people with HIV need earlier treatment (Figure 4). It remains a challenge to meet the need for HIV/AIDS services.

Figure 4
Indicators of Need for HIV Services
18,591 Living AIDS Cases as of 12/31/97



*estimated unduplicated Service Program Clients, data from earlier years not available.

HIV Prevalence Estimates

Based on World Health Organization estimates, the prevalence of HIV is higher than ever before (over 29.4 million children and adults infected). Despite the recent decline in AIDS cases and deaths, HIV cases appear to be unhampered and the drug combinations do not work for everyone. Texas is currently unable to provide reliable HIV prevalence data. There are no reliable data sources to draw upon for any estimates in Texas at this time. What has been demonstrated, however, is that the most recent data (1997), from the Survey of Childbearing Women (SCBW), demonstrates an HIV prevalence rate of 1.05 per 1000 women, which is similar to the rate that was found in the 1995 SCBW, (.93 per 1000 women). If data from child-bearing women, statewide, can be generalized for the remaining population of Texas, then it would appear that the HIV prevalence is fairly stable at this time. This is a questionable generalization, however.

HIV Reporting

The time from initial infection with HIV until a person develops an AIDS defining condition may span years; therefore, AIDS case reports do not include those recently infected. HIV infection reports tend to identify more recently infected individuals than do AIDS case reports. For health professionals to follow the current trends of HIV disease and to develop prevention strategies, prompt identification and reporting of HIV infections is essential.

HIV reporting is critical to the accurate and timely assessment of disease trends. As mentioned earlier, new drug treatments now available to HIV-infected patients delay the decline of CD4+T-cell counts and delay the progression to an AIDS-defining condition for these individuals. These developments will reduce the usefulness of AIDS case data for analyzing the epidemic and increase the need for better HIV reporting. CDC has been encouraging all states to develop reliable HIV surveillance systems because the AIDS case reporting system is no longer adequate to track the HIV/AIDS epidemic. Work is underway in Texas for approval in 1998 of an HIV surveillance system for statewide reporting. This will enable the State, for the first time, to begin tracking HIV incidence, prevalence and trends, to provide more timely services to HIV-infected persons, and to disseminate more effective preventive education.

Table 2
AIDS Cases Reported in 1997 by Sex and Race/Ethnicity*

Race/Ethnicity	Cases	Males (%)	Rate-Cases per 100,000	Cases	Females (%)	Rate-Cases per 100,000
White	1,660	(43)	31.1	193	(23)	3.5
African American	1,303	(34)	122.4	501	(60)	43.5
Hispanic	898	(23)	31.3	135	(16)	4.8
All Other*	29	(1)	---	1	(<.1)	---
Total Cases	3,890	(100)	40.8	830	(100)	8.5

*The category *All Other* includes any racial/ethnic group not listed as well as those cases not specifying race. Therefore, a rate is not calculated.

Ethnicity, Age and Gender Rates

During 1997, the rate of reported AIDS cases among African Americans (81.4 per 100,000 population) was more than 4 times higher than rates for Whites (17.0) or Hispanics (18.2). Among females, the case rate was 8.5 cases per 100,000 population. In the African American female population, however, the rate was significantly higher at 43.5 cases per 100,000. The Hispanic and the White female rates were lower: 4.8 and 3.5, respectively. The 1997 AIDS rate for males (40.8 per 100,000 population) was much higher than that for females (8.5). The African American male population had the highest rate, 122.4, followed by Hispanic males at 31.3 and White males at 31.1 AIDS cases per 100,000 population (Table 2). Of the AIDS cases reported in 1997, 17.6 % were among women, compared with only 9% in 1992. In 1997

African Americans composed 46.4 % of cases, an increase from 24% in 1992. These shifts indicate that HIV is spreading among women and African Americans.

Recent studies have emphasized the significance of Sexually Transmitted Diseases (STD's) in the transmission of HIV. Ulcerative manifestations, in particular, such as syphilis, chancroid and herpes, offer a portal of entry for HIV, while mucopurulent and inflammatory processes, such as those in gonorrhea and chlamydia provide abundant target cells (CD4+) with easy access for HIV. HIV prevalence appears to be shifting to coincide with the classic STD (syphilis and gonorrhea) prevalence patterns.

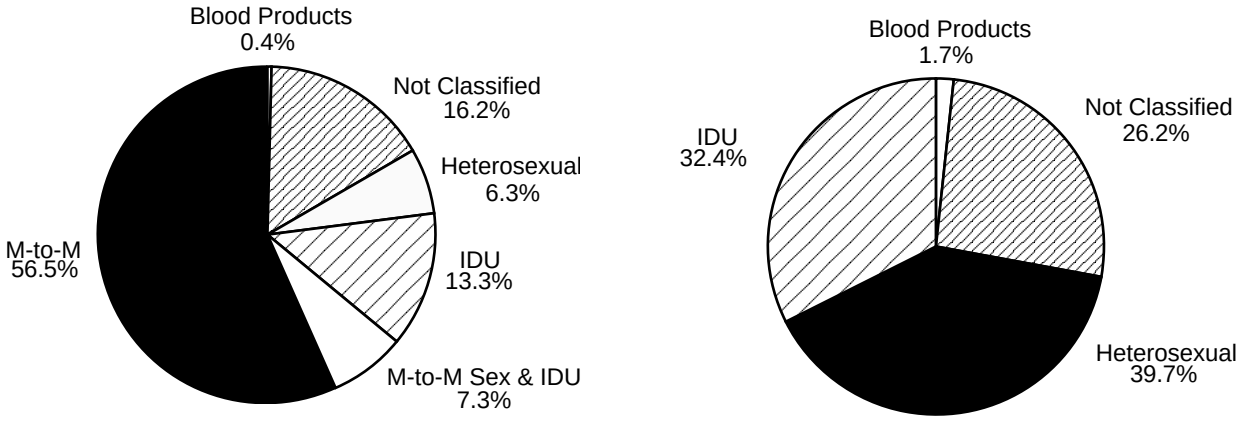
The 20 to 44 year-old age group demonstrated the highest AIDS rate in 1997, at 49 cases per every 100,000 Texan. The 45+ year-old age group exhibited the next highest rate at 15 cases per 100,000 Texan. As of 1997, the teenage group, (13 to19 year-old age group), had a lower AIDS rate, at 2 cases per 100,000 Texans. These data imply, however, that the teenage group is at high risk of acquiring the HIV infection, since it usually takes 5 to 10 years to develop AIDS following HIV infection. STD incidence (i.e., new cases of disease in a given time frame; in this case a year) is highest in these teen years.

A cumulative total of 2,497 AIDS cases in those aged 13 through 24 had been reported to the Texas Department of Health by the end of 1997. Of these cases, 261 were reported in 1997 alone. The ethnic profile of AIDS cases in the 13 through 24 age group has shifted over the past nine years. In 1988 the composition was 56% White, 19% African American, and 25% Hispanic. In 1997 the composition was 17% White, 50% African American, and 32% Hispanic.

Mode of Exposure

Although lower than in previous years, the exposure category of male-to-male-sex constituted the highest proportion (56.5%) of AIDS cases among men (Figure 5). Injecting drug use was the second most likely route of transmission (13%) for men reported with AIDS in 1997. Among women, 39% were infected through heterosexual contact and 32.0% through the use of injecting drugs. A higher percentage of cases

Figure 5
Adult-Adolescent*AIDS Cases Reported in 1997
Mode of Exposure by Gender



*Age 13 or older at time of AIDS diagnosis. AIDS database 01/28/98

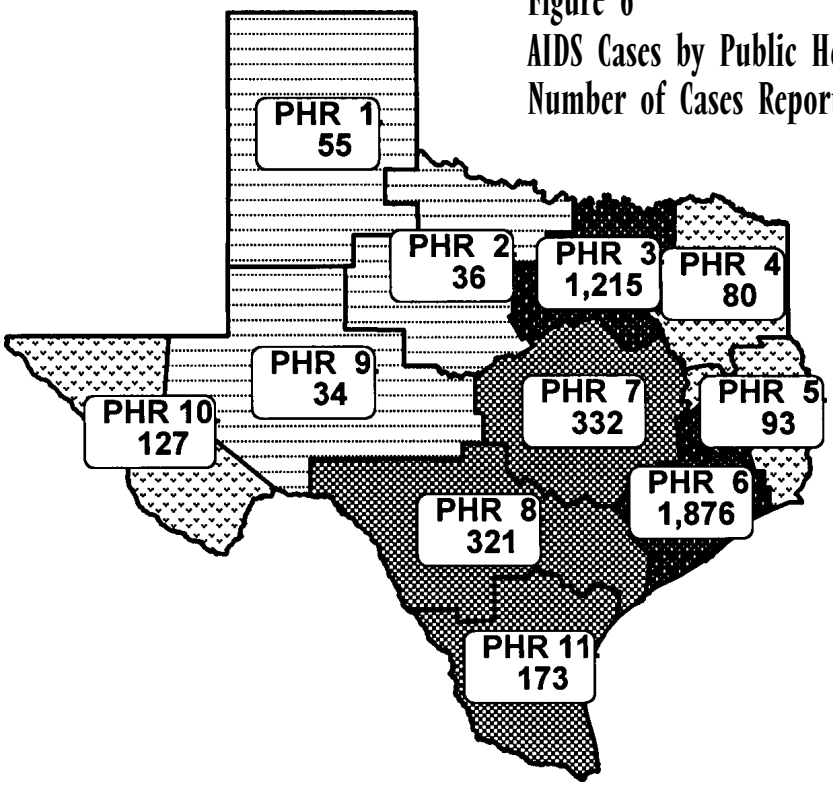
among women (26%) than men (16%) were initially left unclassified as to mode of exposure. For both sexes, the percentage of cases that remain unclassified will decrease as the investigations of risk are completed and cases are reclassified into other categories.

Perinatal HIV transmission has declined dramatically (70%) since 1993, when 915 cases were reported. In 1997, only 278 perinatal HIV cases were reported to TDH. While this number is still too high, the downward trend is very encouraging.

Geographic Distribution

Most AIDS cases in Texas continue to be reported from metropolitan areas, but AIDS has reached all regions in the state (Figure 6). The largest number of cases reported in 1997 was from Harris County (1,712), followed by Dallas (811), Bexar (302), Tarrant (301), Travis (207), and El Paso Counties (127). Ranking these counties by rate slightly affects the order. Harris County had the highest rate (54.3 per 100,000 population) followed by Dallas (38.8), Travis (33.0), and Bexar Counties (22.9). The rates for Tarrant and El Paso Counties were 21.0 and 17.7 cases per 100,000 population, respectively. Only 30 of the 254 counties in Texas have *never* reported an AIDS case. The Texas Department of Criminal Justice reported 7% of all 1997 AIDS cases. Although still centered mainly in the metropolitan areas of the state, the HIV epidemic continues to spread to more rural areas, requiring all counties to face the challenges of providing prevention education, health care, and services. Especially now, when the early aggressive treatment of HIV-infected populations has proven to substantially increase longevity, outreach to high risk populations is extremely important.

Figure 6
AIDS Cases by Public Health Region
Number of Cases Reported in 1997



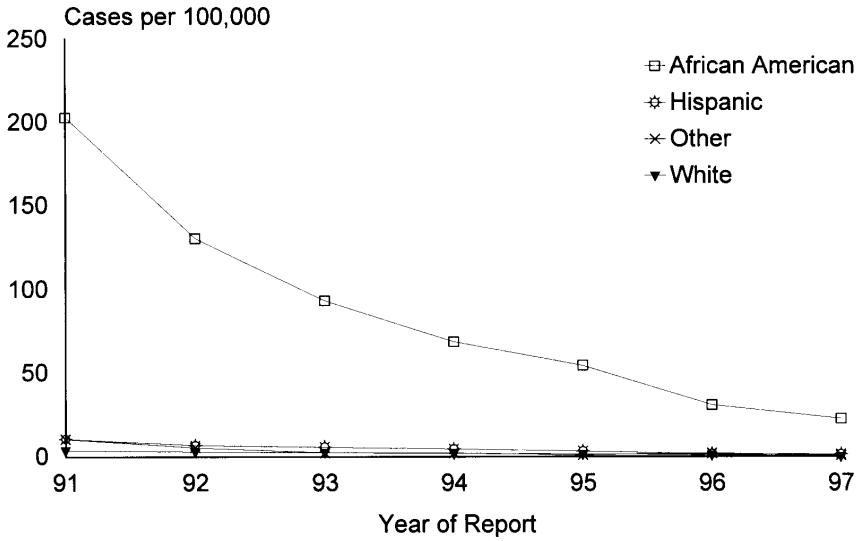
SEXUALLY TRANSMITTED DISEASES

Primary and Secondary Syphilis

Infection with the spirochete *Treponema pallidum* results in syphilis. Primary lesions (ulcer or chancre at the site of infection) followed by secondary infection (manifestations that include rash, mucocutaneous lesions, and adenopathy) characterize the acute form of syphilis. Untreated syphilis progresses into a chronic disease with long periods of latency. Statewide, 683 cases of primary and secondary (P&S) syphilis were reported in 1997. This 43% decrease from cases reported in 1995 continues a downward trend. The number of P&S syphilis cases reported in 1997 was 86% less than the number reported in 1991. The overall state rate in 1997 for P&S syphilis was 3.5 cases per 100,000 population—the lowest rate since 1958. Officials at CDC are calling for the elimination of syphilis altogether (all stages) from the U.S. while the national rates are extremely low. CDC officials believe this is a possibility within the next 5 years.

African Americans continue to account for the majority (73%) of P&S syphilis cases reported in Texas. The rate of P&S syphilis among African Americans was 22.4 cases per 100,000 population in 1997, less than one half the 1995 rate of 53.2 per 100,000 population (Figure 7).

Figure 7
Primary and Secondary Syphilis Rates by Race/Ethnicity: Texas, 1991-1997



Nonetheless, the rate for African Americans remained extremely high compared with other ethnic groups. The case rate for Hispanics was 1.3 cases per 100,000 population, for whites 0.9 cases per 100,000 population, and for other ethnic groups (excluding cases with race unspecified) 0.6 cases per 100,000 population. Among African Americans, women aged 15 to 19 had the highest rate: 56.8 cases per 100,000 population. The highest rate for African American men was found among those aged 20 through 24: 52.4

per 100,000 population. The extremely high case rate for both sexes indicates the continuing severity of the problem of P&S syphilis among young African Americans in Texas.

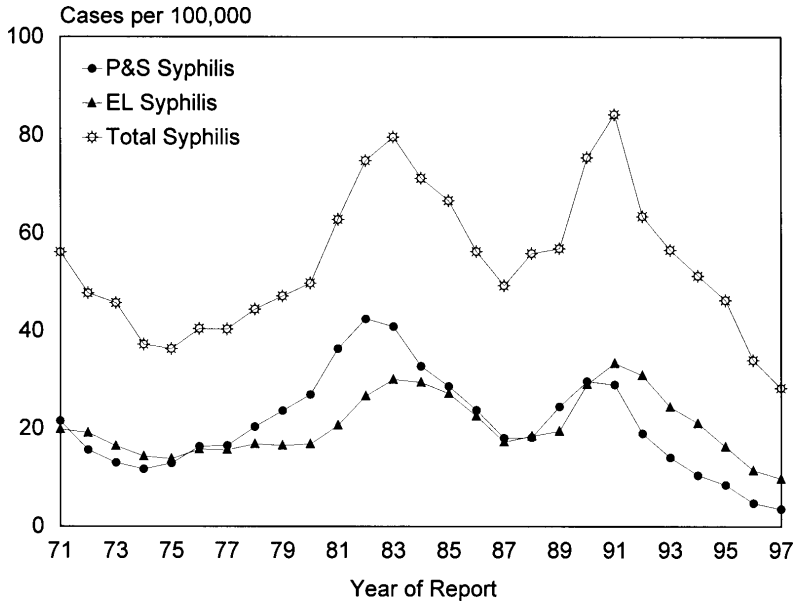
As in 1995, about one-third of the patients with P&S syphilis were aged 15 to 24 years. The number of cases in men and women were almost equal: women accounted for 321 cases (47% of the total) compared with 362 cases among men. In 1997 there were 97 cases of P&S syphilis among those aged 15 to 19 years. Despite the fact that the numbers have steadily declined in recent years, there is still significant racial/ethnic disparity in primary and secondary syphilis prevalence. The case rate for African Americans in this age group (40.6) was 16 times higher than the Hispanic case rate (2.5) and 45 times higher than the White case rate (0.9).

Early Latent Syphilis

The early latent stage of syphilis follows untreated secondary syphilis after a period of weeks or months (less than one year). Untreated cases of more than one year's duration are classified as late latent syphilis. In both early and late latent stages, positive clinical signs are absent, and detection of syphilis relies upon serologic tests.

In 1990 slightly over 5,000 cases of P&S and early latent syphilis were reported with similar rates of 30.4 and 29.9, respectively. Since that time, the rate of P&S syphilis has steadily declined. However, the early latent syphilis rate increased in 1991 and since then has decreased more slowly than the P&S syphilis rate (Figure 8). This delayed decline of early latent syphilis rates is typical of periods of decreasing syphilis morbidity. Although both P&S syphilis and early latent syphilis cases were considerably lower in 1997 compared with 1990, the number of early latent syphilis cases (1,876) was almost three times the number of P&S syphilis cases. The 1997 overall rate of early latent syphilis was 9.7 cases per 100,000 population. The case rates (cases per 100,000 population) for early latent syphilis by race/ethnicity were as follows: African Americans, 55.7; Hispanics, 6.7; Whites, 2.0.

Figure 8
Syphilis Rates: Texas, 1971-1997



In 1997 African Americans constituted 72% of all early latent syphilis cases, followed by 14% Whites and 10% Hispanics. Women aged 15 to 24 years made up 40% of all females with early latent syphilis while men in this age group accounted for only 23% of all cases in males.

Congenital Syphilis

Congenital syphilis, one of the most serious forms of the disease, may cause abortion, stillbirth, or premature delivery, as well as numerous severe complications in the newborn. In 1997, 160 cases of congenital syphilis were reported, marking the fifth straight year of decline. The lower number of congenital syphilis cases in 1997 represented a 2% decrease from 1996 and a 35% decline from 1993, when 246 cases were reported. With 108 cases in 1997, Harris County had the highest number of congenital cases, slightly fewer that the122 cases reported from that county in 1996. The increase in 1996 was probably due to improved adherence to the congenital syphilis case definition and likely does not reflect a true rise in incidence. Tarrant County had the second-highest numbers with 12 cases. Statewide, 55% of congenital syphilis cases were in African Americans; 33%, Hispanics; and 6%, Whites.

Chlamydia

Infections caused by the bacteria *Chlamydia trachomatis* are the most common of all sexually transmitted diseases. Chlamydia infection in women can result in serious complications such as pelvic inflammatory disease, ectopic pregnancy and infertility. After chlamydia became reportable in 1987, the number of cases soared, reflecting increased testing but not increased disease. Reports of chlamydia in 1997 totaled 50,661, an 18% increase from the previous year's total of 43,003.

Statewide, the total number of clients screened by public funding increased 27% (from 280,102 in 1996 to 354,889 in 1997); the number of positives resulting from those screenings increased by 5,781 (from 18,327 to 24,108 positives). The increased screening may account for much of the apparent increase in cases.

Of the total chlamydia cases reported in 1997, 86% were in females. Women are more likely to be screened for chlamydia during clinical exams for family planning, prenatal care, and routine pap smear testing. Because of the increased risk of severe outcomes (including the potential to infect a newborn child), chlamydia screening programs focus on women. Males are often asymptomatic and therefore do not seek treatment. Given that men are not targeted for testing and thus make up such a small proportion (less than 15%) of chlamydia cases reported, it is not possible to estimate the true incidence of chlamydia in the Texas population.

Due to the overwhelming proportion of cases among women, rates of chlamydia infection for each sex should be examined separately. The 1997 case rate for females was 435 cases per 100,000 population with African American women having the highest rate (650) followed by Hispanic women (591) and whites (116). Examination of the case rate in men demonstrated the same racial/ethnic distribution as women but with far lower rates. However, if males were equally targeted for screening and testing, incidence among males would be higher than suggested by case reports.

Over 60% of all reported chlamydia patients were aged 15 to 24 years of age. Among the more than 27,000 cases reported for women 15 to 24 years of age alone, the rates for chlamydia among young women age 15 to 19 years and 20 to 24 years were 2,214 cases and 1,789 cases per 100,000 population, respectively.

Gonorrhea

Infection with the bacteria *Neisseria gonorrhoeae* results in clinical gonorrhea. Left untreated, gonorrhea may lead to sterility in men and pelvic inflammatory disease, ectopic pregnancy, and sterility in women. The 26,617 gonorrhea cases reported in Texas in 1997 represent a 16% increase from the number of cases reported in 1996. In Texas, the rate of gonorrhea had been steadily decreasing since 1978, when it reached a peak of 683 cases per 100,000 population.

The 1997 overall rate for gonorrhea was 138 cases per 100,000 population, higher than the 1996 gonorrhea rate (122 per 100,000) but still lower than the 1995 rate (165). The female rate was 140 cases per 100,000 population, slightly higher than the male rate (135). Among age groups, the highest rate for females was found in women aged 15 to 19 years (665 cases per 100,000 population) followed by those aged 20 to 24 years (515 cases per 100,000 population). Men in these age groups also had higher rates than did males in other age groups. Gonorrhea among women aged 15 to 24 years comprised 60% of all cases in females; men of the same age group accounted for 38% of all gonorrhea cases among males.

As noted for Chlamydia, increased screening may be responsible for this rise. Statewide the total number of publicly funded screenings increased 23% (from 294,183 in 1996 to 357,317 in 1997); the number of positives resulting from these screenings rose 34% from 10,965 to 14,689 between 1996 and 1997.

The rate for African Americans (677 cases per 100,000 population) is over 8 times greater than that for Hispanics (79 cases per 100,000 population) and 27 times higher than the rate for whites (25 cases per 100,000 population). African American men had the highest rate of all race-sex groups with 768 cases per 100,000 population. As was seen for the entire population, African Americans aged 15 to 24 years accounted for the greatest share of African American cases (49% of those reported); they also represented 27% of all cases reported, regardless of race or age.

The highest rates of gonorrhea occurred in eastern Texas. This is not surprising considering that African Americans have a high rate of gonorrhea and that more African Americans live in east Texas than in other areas of the state. The lowest rates of reported gonorrhea occurred along the border with Mexico.

Pelvic Inflammatory Disease (PID)

PID is a serious, sometimes life-threatening complication of untreated chlamydia and gonorrhea in women. Acute PID caused by chlamydia and gonorrhea increases a woman's risk of recurrent PID, chronic pelvic pain, ectopic pregnancy and infertility. In 1997, 1341 cases of PID were reported, a 35% increase from the 991 cases reported in 1996, and similar to the 1,261 cases reported in 1995. PID attributed to gonorrhea accounted for 14% of all cases reported while 21% of cases were related to chlamydia infection. Almost 35% of PID cases were of undetermined etiology. Young women aged 15 through 24

accounted for 47% of all cases; African American women accounted for 41% of all cases. Because PID reporting is voluntary, the cases reported most likely reflect only a portion of all the cases that occur statewide in any one year and reporting may fluctuate. However, more active surveillance in sentinel sites may explain the majority of the increase in PID. For example, in 1996 Harris County reported 25 cases of PID; this number rose to 362 cases in 1997.

Sexually Transmitted Diseases Among Adolescents

Adolescents are at high risk for acquiring a wide array of STDs for several reasons: they may be more likely than others to have multiple sexual partners rather than a single, long-term relationship; more likely to engage in unprotected intercourse; and more likely to select partners at higher risk of having STDs. During the past two decades, the age of initiation of sexual activity has steadily decreased.

U.S. and Texas Adolescent Statistics

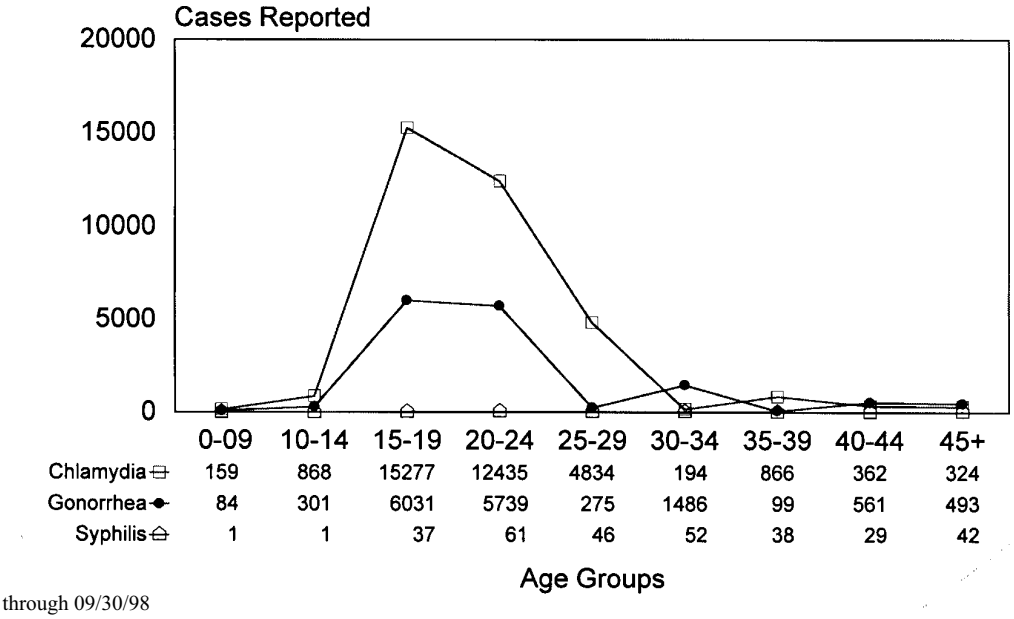
The total burden of STD's is estimated at 12 million new infections annually in the United States Of these, 3 million occur among teenagers. In this country, STD's are the most common reportable diseases and recently several studies have linked HIV transmission to the presence of STD's. There is now strong evidence that other STD's increase the risk of HIV transmission, and conversely, STD treatment reduces the risk of acquiring HIV. Studies indicate that people are 2-5 times more likely to become infected with HIV when other STD's are also present. The open lesions of herpes and syphilis allow a portal of entry for HIV viruses, while the inflammatory and mucopurulent nature of gonorrhea and chlamydia provide numerous target cells (CD4 cells) for increasing susceptibility. About two-thirds of all STD infections generally occur among persons under 25 years of age and predominantly among minority populations. Prevalence studies in various clinic populations and large-scale screening projects have consistently demonstrated that younger women have higher positivity rates of chlamydia than older women.

Of the 85,660 cases of all STDs reported in Texas in 1997, almost 60% were among those aged 15 through 24 years old (Figure 9). Almost 30% of these cases were from adolescents 15 to 19 years old. Minority youth make up a disproportionate share of these STD cases. The 1997 STD case reports that included ethnicity information for those aged 15 through 19 were comprised of 36% African American, 31% Hispanics, 15% white, and <1% other ethnicities. The STD case rate for African Americans was more than 2 times higher than the Hispanic rate and 5 times higher than the rate for whites.

Gonorrhea cases reported in 1997 among those aged 15 through 19 numbered 7,509 and accounted for 28% of all gonorrhea cases. The case rates for this age group by race/ethnicity per 100,000 population were African American: 2,002, Hispanics: 287, and Whites: 114.

Chlamydia cases reported in 1997 numbered 18,551 for this age group (15 to 19 year old) and accounted for 37% of all cases reported. The case rates for this age group per 100,000 population were African American: 2,800, Hispanics:1,291, and Whites: 442. The true incidence of chlamydia may be much higher because it is usually asymptomatic and detected only by the screening of those seeking medical care for other reasons. Also, women are more likely to be screened than men; 84% of all cases reported in 1997 were among women.

Figure 9
Selected STD's by Age Group: Texas 1997



Data through 09/30/98

Primary and secondary syphilis cases reported in 1997 numbered 97 among those aged 15 through 19 and accounted for 14% of all primary and secondary syphilis cases. The case rate for African Americans (40.6 per 100,000 population) in this age group, was 16 times higher than the Hispanic case rate (2.5) and 45 times higher than the white case rate (0.9).

The cost of STD treatment and related services is estimated at over 10 billion dollars annually. For Texas, the cost of treating uncomplicated STDs for those 15 through 19 years of age in 1997 was at least $2.5 million. Every dollar spent in Texas for the prevention of STDs saves ten dollars in medical costs.

Although young people have a greater risk of being infected with an STD other than HIV, these "traditional" STDs receive less attention than HIV. Prevention methods for both HIV and STDs overlap, but teaching adolescents to recognize the symptoms of traditional STDs and to seek treatment early may prevent more severe forms of the diseases from developing. Educational programs and preventive messages need to be developed and delivered by parents, teachers, religious leaders, youth leaders, professionals working with adolescents, peers, media, and role models. Young people themselves, serving as peer educators, should be enlisted and relied upon as an important part of all STD prevention efforts.

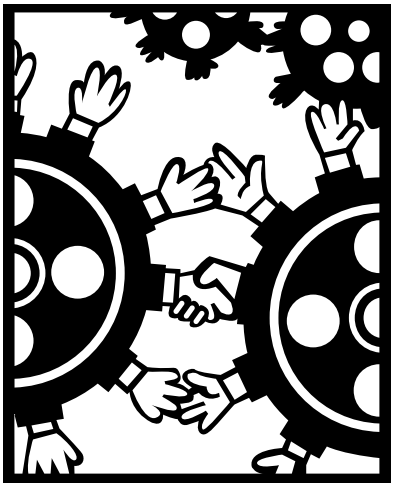
V. HIV PREVENTION AND SERVICES

HIV PREVENTION

The three components of the HIV Prevention program are Health Education and Risk Reduction (HERR), Prevention Counseling and Partner Elicitation (PCPE), and Public Information. All components of the prevention program‘ are planned through a community planning initiative mandated by the Centers for Disease Control and Prevention (CDC) in 1993. The TDH awarded 7.6 million dollars directly to local health departments and community based organizations providing prevention services to their communities in 1997.

Community Planning

Community planning is the process which enables local communities to identify, plan and determine prevention priorities within the regions. The TDH will use the priorities identified by the HIV Regional Planning Coalitions in the establishment of future HIV Cooperative Agreements with the CDC. The TDH, in partnership with the ten HIV Prevention Regional Planning Coalitions (Coalitions), instituted major initiatives in the community planning process in 1997.



Community planning in Texas has evolved from a single decision-making body heavily influenced by TDH to a partnership with ten community planning groups that represent the geographic and cultural diversity of Texas. The Coalitions are responsible for determining community priorities and intervention strategies based on local and regional needs assessment. The Coalitions and the TDH jointly develop a comprehensive HIV prevention plan that identifies populations with the highest rates of HIV infection and prioritizes interventions and strategies to prevent HIV infection in identified populations. The TDH uses this plan to allocate HIV prevention funds.

The goal for each Coalition is to seat members who represent the unique profile of affected populations within its jurisdiction. An open nomination process for membership ensures parity, inclusion and representation (PIR) from those most affected by HIV. The Coalitions include those who are affected, infected and at highest risk for HIV infection, persons with expertise in social and behavioral science, epidemiology, and HIV prevention interventions, and local HIV prevention workers. Membership in the Coalitions represent the cultural, ethnic and other diversities of the Texas population most affected by HIV and AIDS within the Coalition jurisdiction.

The HIV Prevention Regional Planning Coalitions are in a 2 year planning cycle (1997-1998). During this planning cycle, the Coalitions will review epidemiological and needs assessment data, behavioral science literature on prevention interventions, and complete a priority setting process to develop the Regional Action Plans. The 1999 Comprehensive HIV Prevention Plan to be submitted to CDC in October of 1998 for implementation years 1999, 2000, and 2001 will be a compilation of the ten Regional Action Plans.

Accomplishments

- The ten Coalitions, in partnership with the TDH, submitted the *1997 Comprehensive HIV Prevention Plan*, developed in the previous planning cycle for implementation in 1996, 1997 and 1998. Thirty targeted subpopulations, with specific interventions tailored to meet the needs of these groups, were identified as a priority for prevention funding. The subpopulations were categorized in one of three Behaviorally-Defined Target Populations (BDTP): persons at highest risk of HIV infection or reinfection through male with male sexual activity (MSM); persons at highest risk of HIV infection or reinfection through injecting drug use (IDU); and persons at highest risk of HIV infection or reinfection through unprotected heterosexual sex (UHS).

- The TDH used a variety of communication sources to educate the general public on community planning, such as sample brochures, public notices and other informational materials. The TDH HIV/STD Prevention web page contains information on HIV prevention community planning, the roles and responsibilities of community planning groups (also known as CPGs or HIV Prevention Regional Planning Coalitions), frequently asked questions regarding community planning and contact information for the CPG Co-chairs.

- In October 1997, the TDH also distributed information and updates on community planning to the HIV/AIDS Interagency Coordinating Council, whose members are from other State agencies, such as the Texas Education Agency, the Texas Department of Criminal Justice, the Texas Commission on Alcohol and Drug Abuse, and the Texas Youth Commission.

- At the regional level, the Coalitions marketed the community planning concept and solicited membership through varying methods, which included soliciting participation from organizations; conducting town meetings; distributing informational materials, such as brochures and newsletters; and distributing promotional materials, such as tee shirts and magnets.

- In February 1997, a work group was convened to develop a format for regional action plans that was uniform, user-friendly and technically defensible. The new format is used throughout all ten HIV Prevention Regional Planning Coalitions to insure consistency in organization and planning in their next Regional Action Plan.

- PIR guidelines were created in 1995 by a statewide workgroup of CPG members and TDH staff and were based on the 1995 epidemiological profile. In 1997, the guidelines assisted the ten CPGs in developing and maintaining a membership that closely resembles the demographics of the epidemic in their region in terms of mode of transmission, gender, and race/ethnicity, and the TDH regularly monitored the CPGs to ensure the representativeness of CPG membership in the regions.

- The TDH developed and facilitated member orientations for four of the ten HIV Prevention Regional Planning Coalitions. The member orientation was designed for current and new members to gain an understanding of the history, processes, and the roles and responsibilities of members in community planning.

- In 1997, consultants from the Health Education Training Centers Alliance of Texas (HETCAT), with whom the TDH contracted in 1996, developed and facilitated training in needs assessment for the HIV Prevention Regional Planning Coalitions to ensure uniformity of data collection. Seven of the ten Coalitions requested and completed needs assessment training.

- All CPGs conducted a needs assessment of their region, utilizing focus groups and key informant interviews within major high-risk populations. The TDH and HETCAT monitored the degree of geographic distribution of the data collected. Technical assistance was given to the CPGs to determine the data collection format and the most appropriate instruments and to suggest changes and additional data collection where indicated.

- All CPGs were provided with data on subpopulations and interventions to be addressed by TDH prevention contractors to include as part of their resource inventory for their next Regional Action Plan. Several Coalitions collected resource inventory data on organizations that were not funded by the TDH. CPGs were encouraged to collect resource inventory information on a continuous basis, updating their inventories as they became aware of new providers of prevention services and other regional resources.

- TDH increased technical assistance to Coalitions to improve their ability and capacity to produce regionally representative HIV prevention plans. The technical assistance included training in infrastructure development, assistance in analysis of epidemiological data collection, guidance on applying behavioral science theory to prevention interventions, and data collection methods.

- Each CPG began drafting a Regional Action Plan (RAP) for implementation years 1999, 2000 and 2001. The RAPS will eventually include priority subpopulations and interventions based on the needs assessment data and the priority setting process conducted in 1997.

- In November 1997, the CPGs identified regional issues to be discussed in 1998. The Co- chairs will decide at a later date the methodology for resolution of the issues. In addition, it was decided that two issues, PIR and Prevention Evaluation, will be addressed in a work group. The 1998 regional issues are as follows:
  1. By-laws
  2. Membership
  3. PIR
  4. Community Planning Structure
  5. Clarification of Collaboration
  6. Priority Setting.

Future Plans

1. CPGs will complete their RAPs and submit them to TDH Planning for technical review and inclusion in the 1998 Grant Application.

2. In May 1998, the TDH and the HETCAT consultants, with the assistance of the Coalitions, will develop and administer an evaluation of the community planning process, in order to determine which processes are working well and which need to be strengthened.

3. The CPGs and TDH will discuss and study ways to redesign their structure to insure effective implementation of community planning and to assist rural CPGs in maintaining representation in the process.

4. In 1998, Coalitions will provide peer technical assistance to other CPGs both within and outside the state. Co-chairs for the Coalitions will attend out of state conferences to make presentations on issues such as social marketing, rural interventions, and other strategies identified by CPGs through the priority-setting process.

5. The TDH and the CPGs will create a work group to review the current PIR guidelines. The objectives of the work group are as follows: to develop and apply criteria for selecting individuals for membership to the HIV Prevention Regional Planning Coalitions; to develop a procedure to identify representatives from identified socio-economic groups; and to develop a procedure to address and outline a system for re-examining group composition.

6. The needs assessment process will be reviewed by the TDH, HETCAT, and the Research & Program Evaluation Branch (R&PE), as well as the Coalitions, to determine the most appropriate methodology to collect data on the populations who are at risk for HIV infection or reinfection. The development of a more uniform, standardized tool will be discussed in order to compare data across regions.

Health Education and Risk Reduction

The goal of the Health Education and Risk Reduction (HERR) component is to prevent the spread of HIV by educating high risk persons about disease transmission, assisting them in establishing realistic, personalized risk reduction plans and providing them with the skills needed to remain HIV free. TDH staff develop and manage the competitive application and review process for selecting HERR contractors who will provide health education/risk reduction within their communities. This competitive application is based on a plan developed by each of the 10 independent community planning groups. These public and private contractors target specific populations with HIV health education interventions designed to convey prevention messages in culturally sensitive, appropriate language and form. The majority of the direct delivery staff are indigenous to the population served or are sensitive to the situation of the targeted population, which helps them establish and maintain the rapport necessary for effective communication. They conduct activities in a variety of sites such as community hangouts, streets, parks, jails, STD waiting rooms, schools, local health department clinics, and other local agencies.

TDH staff also provide technical and programmatic assistance, as well as conduct monitoring of HERR contractors. In addition, TDH staff provide technical assistance to organizations to help them in evaluating their programs and demonstrating the effectiveness of their interventions. This ensures that contractors are consistent in their implementation of HIV prevention interventions, and that contract dollars are spent in accordance with accepted contract objectives. Another important role of this component is to provide ongoing information and HIV educational material to both contractors and non-contractors for distribution to the general public.

Accomplishments

- HERR contractors provided over 213,000 contacts and exceeded targeted contacts in all categories of behaviorally identified target populations.

- HERR contractors dispensed over 4,184,000 condoms throughout the State.

- The TDH-supported Intensive Behavioral Counseling (IBC) Project at the University of North Texas at Denton ended in December, 1997. The Project found that intensive behavioral counseling can reduce risky behavior in individuals. It also found that bachelor level counselors could learn to work with clients and produce meaningful and measurable results, without the need for extensive formal training. Certain personal characteristics were identified as good indicators of what types of individuals make good counselors. The project trained 21 counselors and enrolled 60 clients.

- The TDH awarded an RFP to the AIDS Prevention Project at the University of Texas Southwestern Medical Center at Dallas to assist TDH in developing a system that will guide contractors in reporting HIV prevention activities and help organizations evaluate their programs.

Future Plans

- The TDH will continue to direct HERR contractors to provide HERR intervention activities in outreach settings performed by peer members of the target populations. Peer is defined as a member of a particular population or one who is sensitive to the issues affecting that population. Peer outreach will be conducted at locations identified by Coalitions where high risk activity takes place or where members of the target populations congregate. In addition to individual level interventions, group and community level interventions will be undertaken.

- The TDH will continue to provide guidance and technical assistance to ensure that HERR contractors reach the targeted populations as outlined by the Regional Planning Coalitions.

- The TDH will implement new data collection instruments for use in program evaluation and monitoring.

Prevention Counseling and Partner Elicitation

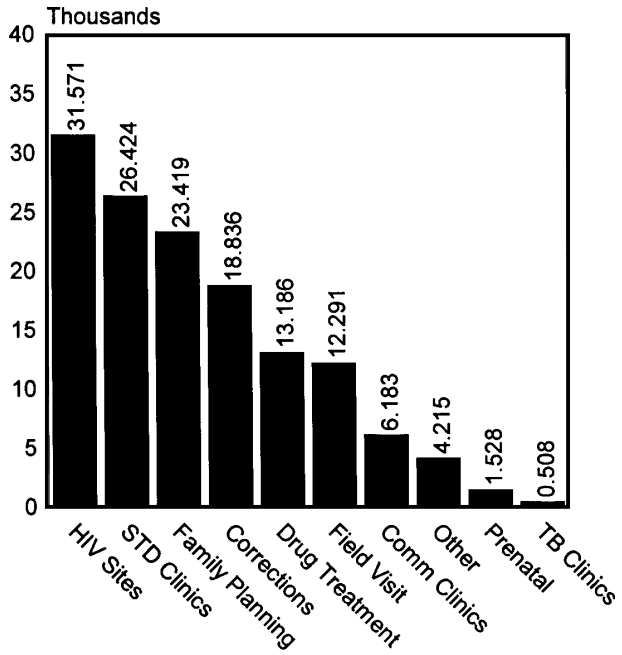
TDH provides Prevention Counseling and Partner Elicitation (PCPE) services statewide, primarily through contracts with local health departments and community based organizations.

Prevention Counseling is client-centered, interactive and responsive to individual client needs. The focus of prevention counseling is on developing prevention goals and strategies with the client rather than simply providing information. Counselors must understand the unique circumstances of each client (e.g., behaviors, sexual orientation, race/ethnicity, culture, knowledge level, and social and economic status). Counselors engage clients in Test Decision Counseling, a process to help clients reach their own decision about whether to take an HIV test, which includes assessing and supporting client readiness for testing and coping with the results.

When clients return to learn their test results, they always receive personal post-test prevention counseling. If the client tests negative for HIV infection, post-test counseling reinforces behavior changes identified by the client to keep from becoming infected. If the client tested positive for HIV, post-test counseling encompasses a range of issues. The PCPE staff provide referrals to link clients with medical, psychological and social services. They also elicit the names of sex and/or needle sharing partners in order to assist the client in managing confidential partner notification, handled by Disease Intervention Specialists, so that others at risk can be given the opportunity to receive counseling and learn their HIV status. Finally, post-test counseling reinforces behavior changes the client has identified to maintain personal health and prevent transmitting the infection.

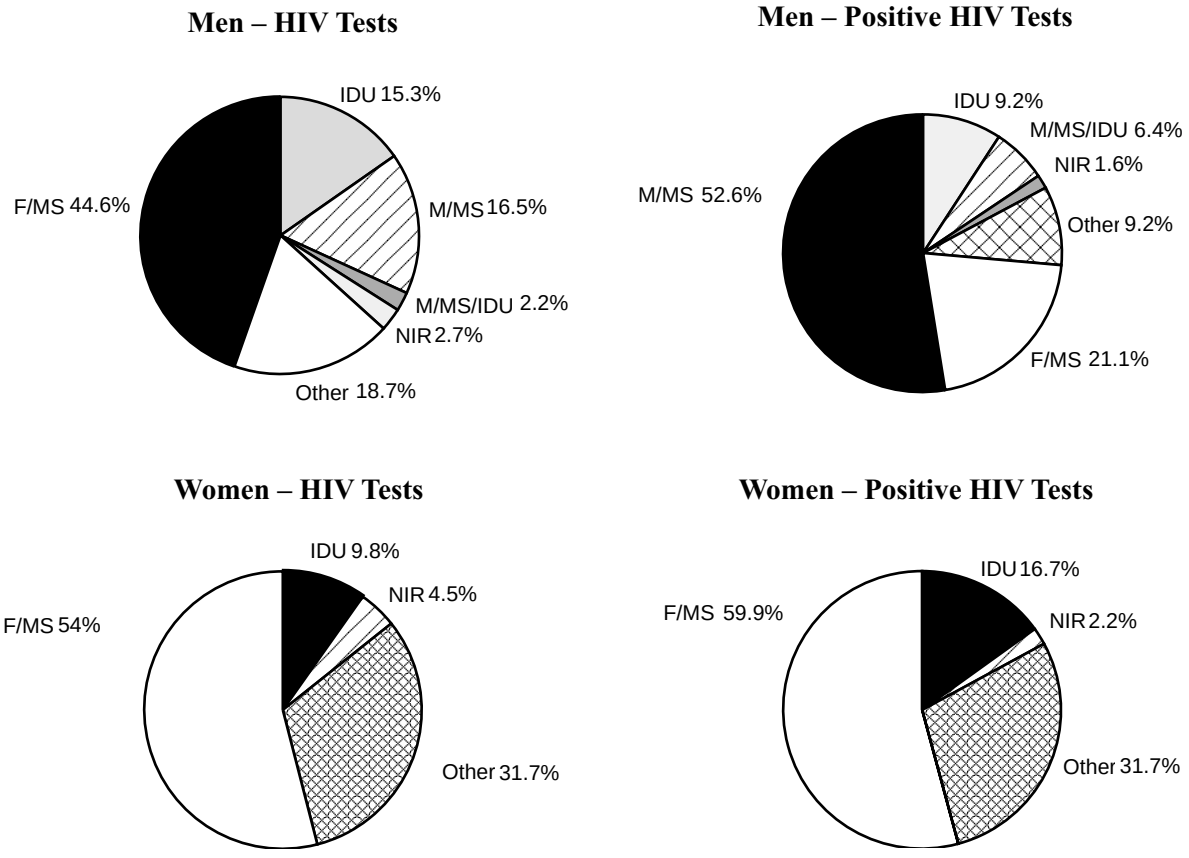
TDH staff provide technical assistance to contractors and monitor contracts to ensure compliance with objectives and appropriate use of program funds. Additionally, the PCPE component maintains data

Figure 10
HIV Clients Served by Agency Type



collection and reporting systems that provide important information for planning and implementing prevention activities. The TDH collects data on the number of persons tested by type of agency/testing site (Figure 10), and by gender and mode of exposure (Figure 11). Mode of exposure is a way of dividing risk behaviors based on the likelihood of transmitting HIV while engaging in that behavior. The mode of exposures are listed in order of risk of transmission of HIV, beginning with the riskiest. These modes are: 1) men who have had sex with other men and also use injecting drugs (M/MS/IDU), 2) men who have sex with other men (M/MS), 3) injecting drug user (IDU), 4) risky heterosexual sex (F/MS), 5) other exposures not identified above (Other), and 6) no indicated risk (NIR). The TDH uses this information to determine which populations are currently at greatest risk of HIV infection, and to identify the specific behaviors that put people at risk.

Figure 11
Percentage of Tests and Percentage of Positive Tests by Gender and Mode of Exposure, Texas 1996



Accomplishments

- The TDH awarded an RFP to the AIDS Prevention Project at the University of Texas Southwestern Medical Center at Dallas to assist TDH in developing a system that will guide contractors in reporting Prevention Counseling activities, help organizations evaluate their programs, and provide community planning groups with more detailed information that will help them target their prevention programs.

- PCPE contractors provided 138,161 HIV antibody tests throughout the State in 1997. Of these, the total number of positive tests was 1,515. The positivity rate fell from 1.5 positives per 100 tests in 1996 to 1.1 per 100 tests in 1997.

- Nearly 90% of HIV positive clients identified at PCPE contractor sites in 1997 who returned to learn their results and receive post-test counseling were referred to an early intervention system of care.

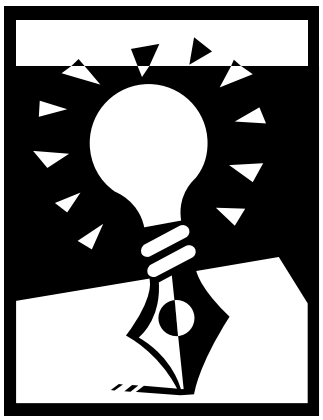
- To determine the extent of compliance with HB1345, the Texas law that requires that all pregnant women be offered an HIV test by health care providers, the TDH performed a *Survey of Private Obstetric Practices* and analyzed birth certificate data recorded between January and July 1997. The survey of private practices found that 98% of the practices that had treated a pregnant patient in the last year discuss HIV testing with all pregnant patients, with 96% of the practices routinely including an HIV antibody test as part of the tests run on pregnant patients at intake. The analysis of birth certificate data showed that the proportion of women who received HIV testing either pre- or perinatally was 94%, with 85% of the certificates indicating that prenatal testing had been done, and 74% of the certificates showing evidence of HIV testing at birth.

Future Plans

- The TDH will implement new data collection instruments for use in Prevention Counseling that may be used for program evaluation and monitoring.

- The TDH will continue to provide guidance and technical assistance to ensure that PCPE contractors reach the targeted populations as outlined by the Coalitions.

- The TDH will evaluate current HIV prevention data systems and develop new data collection instruments for use in program evaluation and monitoring.



- The TDH will continue to emphasize the importance of augmenting on-site, clinic-based counseling and testing services with PCPE services provided at non-traditional sites with the goal of making counseling and testing services more accessible to the target populations identified by the Coalitions. Non-traditional sites refer to field testing that occurs in places where high risk activity involving a target population takes place or where members of the target population who participate in high risk activity congregate.

- In a further effort to expand accessibility, PCPE contractors are expected to use counselors who are peers of the targeted populations. Peers are defined as members of the targeted population, or trained individuals sensitive to issues affecting that population.

HIV SERVICES

Texas HIV Services projects were established in 1989 in response to *AIDS in Texas: Facing the Crisis*, the final report of the Texas Legislative Task Force on AIDS. In supporting basic treatment and health and social services to HIV infected Texans, the Texas Legislature charged the HIV/STD Health Resources Division (Division) to:

- coordinate the use of local, federal and private HIV Services funds;
- encourage the provision of community based HIV services;
- address needs not met by other funding sources;
- provide statewide distribution of HIV Services funds that reflect regional needs; and
- encourage cooperation among local HIV service providers (Health and Safety Code, Chapter 85, sec. 85.032).

Additionally, the reauthorized Ryan White CARE Act of 1996 mandated the development of a *Statewide Coordinated Statement of Need (SCSN)*, the purpose of which is to provide a mechanism to collaboratively identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWH/A) and to maximize coordination, integration, and effective linkages across the CARE Act Titles related to such issues. The mandate requires participation in the development of the SCSN by CARE Act recipients. Guidance for the project was developed by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS), with active participation from HIV/AIDS Program Directors, Title I and Title III grant recipients, the National Alliance of State and Territorial AIDS Directors (NASTAD), various constituent groups, and PLWH/A. The SCSN has become a multi-year, long-range project which will:

- ensure representation from consumers and all Ryan White grantees across all RW Titles, resulting in collaboration and coordination;
- include a strong emphasis on needs assessment activities;
- identify state systems and activities and services that are already in existence;
- look at how epidemiological data are currently being used at the local level;
- create a better network of local/state communication;
- facilitate capacity development of providers as it relates to HIV services; and
- provide opportunities to collaborate with peers and colleagues statewide.

Service Delivery

During 1997, the Bureau of HIV/STD Health Resources Division, in compliance with both state and federal mandates, distributed over $19 million in HIV service contracts throughout the state. Legislatively appropriated state revenues contributed approximately 35% of the services funds awarded in 1997. Federal Ryan White Title II Comprehensive AIDS Resources Emergency (CARE) ACT monies accounted for 52%. Federal Housing Opportunities for Persons with AIDS (HOPWA) resources contributed the remainder.

To award HIV Service funds as extensively and equitably as possible, the Division divides the eleven Texas Public Health Regions into 26 HIV Service Delivery Areas (HSDAs). Each HSDA is served by a

local HIV CARE Consortium made up of public and private HIV service providers, community based organizations, HIV infected individuals and community leaders. The Consortium determines the needs of its community and allows local providers to coordinate services. This ensures that a wide variety of medical and psychosocial services are available to the local HIV infected population.

The TDH contracts with an administrative agency designated by the Consortium members to manage the TDH award. The funds available to each HSDA are determined through a funding formula based on the population living in the HSDA (50%), the number of AIDS cases reported in the most recent 24-month period (50%), and an adjustment for the local poverty index.

Basic HIV services supported by TDH contracts with local health departments and community based organizations include:

* aerosolized drug therapy
* attendant care
* case management services
* client transportation
* counseling
* day or respite care
* day treatment
* dental care
* diagnostic services
* food pantry
* home health aide services
* home intravenous services
* homemaker services
* hospice care
* housing
* insurance assistance program
* lab services
* medical services
* nutrition services
* physician services
* volunteer services

Physical and mental health services enable HIV infected persons to remain healthier and independent, extending the time they can care for themselves and others without support. HIV services reduce the need for expensive hospitalizations and more costly treatments by providing preventative services and less costly home-based care. Since many HIV/AIDS clients are economically devastated by the disease, many must rely on publicly funded care. Providing cost-effective HIV services benefits all Texas residents by reducing health care costs supported by taxpayers.

Accomplishments

- The SCSN Work Group, established in March of 1996, completed the selection process in June of 1997 to establish the SCSN in Texas. Members were selected based on nominations submitted by the Consortia, Planning Councils, Prevention Coalitions, and Administrative Agencies responsible for HIV programs in Texas. Texas Women's University was selected by the TDH through an RFP process to facilitate the SCSN activities and provide technical assistance to the Steering Committee.

- On August 20,1997, the SCSN Steering Committee initiated a three-year process by holding a video teleconference to discuss the project, its purpose and goals, as well as the Steering Committee and its role and responsibilities. During subsequent meetings held on October 3-4 and November 14-15,1997, the Steering Committee discussed the needs assessment process and the problems associated with its design and implementation in Texas. Data gathered by Committee members were studied during the November meeting to determine weaknesses, gaps and inconsistencies in data collected in the needs assessment process across the state.

- The TDH HOPWA program provided short term rent, mortgage, and utility payments and tenant-based rental assistance to 1,940 clients for the period of February 1, 1997 - January 31, 1998.

- Almost 16,000 clients received basic HIV-related social and medical services in FY 1997.

- In May 1997, the TDH sponsored a joint Title I and II meeting, attended by all Title I Agencies and all but one of the Title II Administrative Agencies. The meeting included information and interactive sessions on the SCSN, the Texas Medication Program, Clinical Resources Issues, Ryan White Evaluation Issues, HIV Policy Issues, Managed Care in Texas, the Legislative Report, Title I Cities Caucus, the 1996 Ryan White CARE Act Amendment Issues, and other topics.

- Ryan White Title II contractors reported positive coordination efforts at the local level with the Tuberculosis (TB) Control Programs. At the State level, the TB Elimination Division and the Bureau continue to collaborate in the areas of education, services and reporting.

- In 1997, approximately 22.1% of clients receiving HIV-related social and medical services were women, infants and children. In recognition that these populations face special barriers to initiating and maintaining services, many HIV contractors piloted innovative outreach and service programs directed at these vulnerable groups.

- A public hearing was held on December 18, 1997, to obtain public input on the 1998 Proposed Plan for the Use and Distribution of Ryan White Title II funds.

- In 1997, the Bureau adopted seventeen new policies to ensure effective administration of Title II funds.

Future Plans

- The SCSN will complete drafting of Texas' SCSN document, to be presented to HRSA in March, 1998. The Steering Committee will set goals for addressing emerging trends and crosscutting issues in years two and three of the project period.

- HOPWA and HUD funding periods will be synchronized to reduce the amount of unallocated funds remaining at the end of each fiscal year, and almost $1 million in past unallocated funds will be distributed in addition to funds allocated for 1998.

- In collaboration with Consortia and administrative agencies, the TDH will continue to expand and revise written policies and procedures for efficient Consortia operation.

- The TDH will continue to provide technical assistance to Consortia and administrative agencies to improve their working relationships and incorporate broad community input into their processes.

- The TDH will perform a *Survey of Publicly-funded providers of prenatal care or HIV testing* to determine the rate of compliance with HB1345.

CASE HISTORIES

Success Story #1

Baby Doe was born at a bus stop in a major metropolitan area to a mom who had no prenatal care. Baby Doe was born with syphilis, 99% crack cocaine in her system and exposure to HIV. Through Child Protective Services, a foster mom was found for Baby Doe, and she was referred to a community-based organization (CBO) contracted by the Bureau to provide HIV services. The CBO was able to obtain rent and utility assistance for the foster mom and referred Baby Doe to a medical care provider. The organization has made insurance co-payments, helped with transportation costs, and trained Baby Doe's foster mom in her special care needs. Baby Doe is receiving the special care she needs to overcome the many problems with which she was born.

Success Story #2

A 20-year old woman tested positive for HIV during a routine prenatal visit. Through intensive case management and transportation assistance provided by a community based organization contracted by the Bureau to provide HIV services, this young woman was able to receive maternal care and maintain her medications. One year after she tested positive for HIV, her baby underwent his last HIV test. At 18 months, he remains HIV negative.

Success Story #3

A 63-year old woman was unexpectedly diagnosed with HIV a year and a half ago. She was in an abusive relationship, suicidal and in poor health. After seeking help from a CBO contracted by the Bureau to provide HIV services, she is now living on her own, going to night school to obtain her GED, making plans to enter computer school, and regularly participates in the CBO's support group. She now has a non-detectable viral load and often states that she will succumb to old age before HIV.

VI. STD PREVENTION AND SERVICES

Sexually transmitted diseases (STDs) are a major threat to the health of Texans. Young women and their children are especially at high risk for STDs and the resultant complications. Babies born to infected mothers are often the ones to suffer the most from STD infections. STDs such as syphilis and HIV are passed to the fetus through the mother's blood while she is carrying the child or at delivery. Others, such as gonorrhea, chlamydia and herpes, are usually transmitted to the newborn at the time of delivery. STDs in children can lead to fetal death, retardation, crippling, blindness, deafness, pneumonia and low birth weight. STDs in women can lead to chronic debilitating pain, ectopic pregnancy, sterility, cancer and death. Adolescents are at higher risk for acquiring STDs for several reasons: a tendency to have multiple partners, to have unprotected sex, and to select partners at high risk. Adolescent women have a physiologically increased susceptibility to infection; furthermore, teenaged women have steadily increased their number of premarital sexual encounters during the past two decades. At the same time, adolescents often encounter the most obstacles to seeking health care. STDs are a particularly significant health problem for economically disadvantaged minority populations.

> For every $1 spent on early gonorrhea and chlamydia detection and treatment, $12 in associated costs could be saved.[1]

The goal of STD prevention and services is to prevent the spread of high priority STDs such as syphilis, HIV, chlamydia, and gonorrhea. The foundation of this effort is built on four primary components: surveillance and case detection through screening, disease intervention activities, direct client services, and training and technical resources. Three of these components are discussed below; training and technical resources efforts are addressed in the Training and Public Education section of the report.

Health care providers and laboratories in Texas are required to report syphilis, gonorrhea, chlamydia, chancroid, AIDS, and HIV infections. Surveillance, the collection and analysis of data about the occurrence of disease, is crucial to the success of any disease control effort. Analyzing case reports provides information needed to plan appropriate prevention and control activities and predict disease trends. The Bureau uses the STD, HIV, AIDS Reporting Electronic System (SHARES) a TDH computerized morbidity surveillance system. Both the TDH regional STD programs and local health department programs collect disease reports within their jurisdiction, and transmit the information to the Bureau central office. The central office monitors the extent of the statewide STD problem and changes in demographic and geographic distribution of cases. This information is used to prioritize problems, allocate program resources, and plan and direct activities to respond to changing conditions. By January 1, 1998, the Bureau

[1] *Institute of Medicine. The Hidden Epidemic: Confronting Sexually Transmitted Diseases. Washington, DC: National Academy Press, 1997, p.7.*

of HIV and STD plans to replace SHARES with the STD*Management Information System (***STD*MIS***). Highly trained Disease Intervention Specialists (DIS) routinely perform syphilis and HIV counseling/ interviewing, case management, and partner notification activities for individuals infected with these STDs. In certain locales where resources permit they also perform targeted gonorrhea and chlamydia case finding. DIS also provide targeted prevention counseling to clients identified as high risk for STD. Prevention Counseling and Partner Elicitation (PCPE) activities are routinely performed with early syphilis and HIV infected individuals. PCPE is applied to both gonorrhea and chlamydia clients as resources allow.

The disease intervention process usually begins when a DIS receives a report of an infected or at-risk client. The DIS locates the person and counsels him or her on ways to handle the infection or exposure and on methods to reduce the risk of acquiring or transmitting STDs and HIV in the future. The DIS elicits the names, addresses, and other locating information of sex and/or needle sharing partners, and through field investigation, locates and refers these partners for examination, treatment and/or counseling. The cycle continues with the identification of each infected partner. When a contact is notified, they are not told who identified them as a potential contact. All disease intervention activities are completely confidential.

The Bureau purchases and distributes medicines for the treatment of priority STDs to regional and local health departments and other key providers through the STD Medication Program. The STD Medication Program is highlighted later in this report. The Bureau also funds local physicians to examine and treat STD patients exposed to syphilis, chlamydia and gonorrhea when no publicly funded facilities are available.

Similarly, the Bureau funds client services delivered by the Baylor College of Medicine Teen Clinic in Houston. Through a cooperative agreement, STD resources support STD examinations and treatment at three clinics. These teen clinics serve high risk adolescent females who otherwise would not seek health care. This partnership ensures that teenagers in Houston have access to needed STD services.

Accomplishments

- Prevention activities provided by STD programs resulted in an estimated $30,000,000 savings in medical costs related to STDs and $18,000,000 in savings related to HIV in 1997.

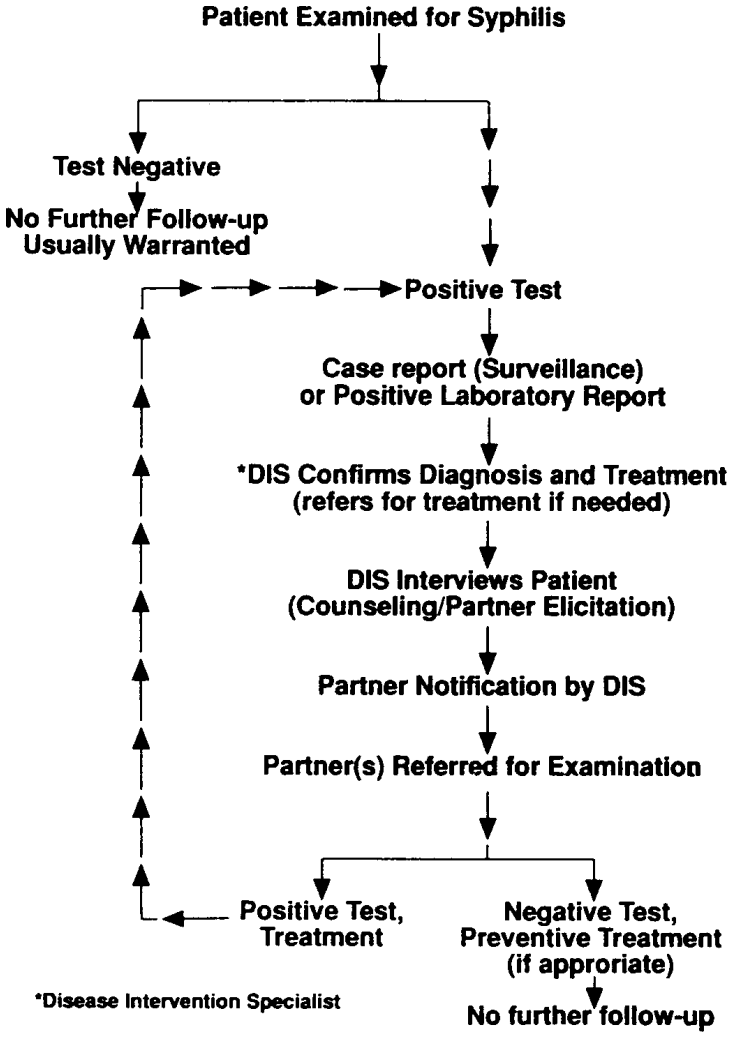
- DIS referred 1,293 syphilis contacts were referred and provided preventive therapy, resulting in the prevention of an estimated 388 cases of syphilis in 1997.

- During 1997, DIS interviewed and managed 2,153 reported syphilis cases.

- DIS provided PCPE to 806 HIV positive individuals in 1997 resulting in the location, counseling, and testing of 775 HIV sex/needle sharing partners. DIS successfully referred 641 (80%) of the HIV positive individuals to early intervention services.

- STD clinics across Texas reported more than 123,000 clinic visits in 1997.

Figure 12
The Disease Intervention Process



- During 1997, the gonorrhea screening program tested 308,730 women, identified 7,202 positives (2.3%) and confirmed treatment on 6,702 (93.1%). The chlamydia screening program tested 307,650 women, identified 19,051 positives (6.2%) and confirmed treatment on 17,795 (93.4%).

- The Bureau collaborated with TDH family planning and maternity clinics and with Planned Parenthood affiliates to provide STD screening and medication to their clients.

- Ten colon*ia* residents,*"Promotoras,"* were recruited in Hidalgo County from among low-income women and teens and trained to conduct STD awareness and education sessions and to make referrals for testing and treatment among their peers. Over 5,600 adults and over 1,800 teens in Hidalgo County were reached in 1997.

- STD programs maintained surveillance activities with physicians, hospitals, public/private laboratories, and community health centers, including site visits to encourage STD reporting and surveillance.

Future Plans

- Field STD programs will continue to establish coordinated efforts with local agencies and programs such as jails, youth detention centers, homeless shelters, and neighborhood health facilities.

- 1998 collaborative activities include exploring additional areas for STD and HIV coordination to maximize program resources and improve or expand delivery of services, especially regarding women offered STD screening outside of STD clinics.

- The Bureau will complete the implementation of STD*MIS, a CDC software package used for surveillance and program management, to local and regional STD programs.

- The Bureau strategic plan will outline priority issues and strategies for STD prevention during the next three years. Some of the strategies identified are:
  - strengthen and expand STD prevention education services;
  - strengthen and expand STD clinical and laboratory services;
  - improve disease and behavioral surveillance for STDs; and
  - increase public support and awareness of STD prevention and treatment.

VII. TRAINING AND PUBLIC EDUCATION

The Training and Public Education Branch (TPEB) plans, develops, conducts, and evaluates HIV and STD training for the TDH, other State agencies, local health departments, and community based organizations involved in HIV and STD activities. HIV and STD training include technical and disease information as well as administrative and managerial workshops. As part of this process, TPEB staff develop program-specific educational materials and guidelines for use in disease prevention activities. Training staff facilitate the delivery of training by:

- Providing direct training for courses as the four-day HIV *Prevention Counseling and Partner Elicitation* (PCPE) course, the 10-day *Introduction to Sexually Transmitted Disease Intervention* (ISTDI) course;

- Providing "Train the Trainer" courses in which Training Branch instructors teach other State agency and community based organization staff to present TDH approved instructional packages;

- Developing and providing customized training to individual programs to address specific needs; and

- Developing, updating, and disseminating HIV/STD curriculums, literature, audiovisuals, and other educational materials.

The Training Branch also maintains the Texas HIV Prevention Counselor Registry of all HIV counselors who have successfully completed the courses required by TDH in order to deliver HIV counseling services in Texas. The Registry includes HIV PCPE counselors trained by the TDH, the Texas Commission on Alcohol and Drug Abuse (TCADA) and the Texas Department of Mental Health and Mental Retardation (TDMHMR) via an interagency Memorandum of Understanding. The Training and Public Education Branch staff provide technical assistance to HIV prevention contractors and STD programs in evaluating their training needs and ensuring those needs are met. The TPEB continues to receive out-of-state participants referred by the Centers for Disease Control and Prevention (CDC) for STD courses. The TPEB is responsible for planning and presenting the annual Texas HIV/STD Conference. The TPEB also compiles and distributes the statewide HIV/AIDS Community Resource Directory and operates the 1-800 bilingual Texas HIV/STD InfoLine. The TPEB is responsible for coordinating the Bureau's staff career development needs and identifying staff training opportunities.

Accomplishments

- The HIV PCPE course was offered 68 times in locations across the State of Texas. Over 600 participants were trained including five hearing impaired participants in 1997.

- Eleven quality assurance reviews were conducted with PCPE trainers across the State in 1997.

- HIV Trainers with TPEB completed CDC training in the curriculum, *"Quality Assurance for PCPE."*

- An STD Slide Package, consisting of a slide presentation and accompanying descriptive list, was produced and distributed to each region and three major local health departments across the state. These packages are loaned out to community based educators and used in STD prevention education programs. The package includes symptom photos of Gonorrhea, Chlamydia, Syphilis, Herpes Simplex, and Human Papillomavirus, and text slides on modes of transmission and prevention.

- A complete section on the Human Papillomavirus was added to the existing course entitled *STD Facts and Fallacies*. The section included a fifteen page script describing the disease's history, prevalence, transmission, course, cancer risk, prenatal and neonatal risks, diagnostic techniques, treatment options, and prevention. Thirty-four slides are shown during this section to illustrate graphs, symptoms, and diagnostic techniques.

- A slide show and lecture were presented to approximately 300 nurses during the National Meeting of the Association of Office Nurses in Austin, Texas. Information on Syphilis, Gonorrhea, Chlamydia, Chancroid, Human Papillomavirus, and HIV was presented followed by a question and answer period. Handouts included Centers for Disease Control and Prevention (CDC) Treatment Guidelines, Texas surveillance report, and papers on RPR interpretation, prevalence and the link between HIV and STD.

- The TDH and the Texas Department of Criminal Justice (TDCJ) entered into an agreement to transfer to the TDH laboratory results of inmates who are paroled prior to receiving their HIV test results and the necessary counseling. This transfer of results allowed local health departments to provide more rapid and thorough service to parolees moving into their jurisdictions. The agreement served as a safety net wherein the TDCJ sent a certified letter referring the parolee to a local health department, and the health department, upon receipt of the results, actively sought out the parolee to notify them of the test results.

- The course *Introduction to STD Intervention* (ISTDI) was modified to include spousal notification in response to the Ryan White Care Act Amendments of 1996. The TDH also modified the course to include a ten-year interview period for past or present spousal partners of HIV infected persons. The TDH has directed programs to make a good faith effort to notify any spouse of a known HIV-infected individual.

- A two day custom course on *Partner Elicitation Enhancement* was developed for HIV prevention contractor staff. The course objectives were to provide necessary skills for successful partner elicitation and address associated problems. The first workshop was done for Family Planning HIV counselors from south and central Texas at their annual retreat.

- The TPEB conducted its 10th Annual HIV/STD Conference at the Hyatt Regency in Austin, Texas on June 29 - July 3, 1997. The target audience included HIV/STD prevention, intervention, and clinical care service providers. Approximately 1,100 registered participants attended from throughout Texas and the U.S. The overall goal was to create cohesive partnerships in order to meet the challenges of HIV, AIDS, and STDs by providing information, skill building, and opportunities for idea exchange among persons living with these diseases and those who provide care, prevention, and other services.

- The TPEB downlinked four video teleconferences for HIV/AIDS/STD health professionals in 1997, including *Taking a Sexual History: How and What to Ask in the 90s*, (7/18/97, 30 attendees); *Treatment of Opportunistic Infections in the HIV/AIDS Patient*, (7/23/97, 11 attendees); *Caring for Adolescents with STDs*, (10/9/97, 25 attendees); and *HIV Prevention Update on Guidelines for Prevention Case Management and Partner Notification*, (10/23/97, 10 attendees).

- The TPEB worked with the American Social Health Association to distribute World AIDS Day resource kits to HIV contractors in order to facilitate a community-based approach to local media coverage of the epidemic. The TPEB also worked with the National Association of People with AIDS to distribute promotional materials to contractors for National HIV Testing Day.

- Pursuant to the Ryan White Care Act Amendments of 1996, the TPEB developed a fact sheet on the new spousal elicitation and notification requirements for individuals reporting cases of HIV infection and AIDS. The TPEB worked with the Surveillance Branch to distribute the fact sheet to everyone who had reported a case of HIV infection or AIDS.

- Four issues of the *Texas HIV/STD Update* were published and distributed to approximately 2,000 subscribers in Texas. The *Update* is the quarterly bulletin for the Bureau of HIV and STD Prevention.

- The Texas HIV/STD Infoline received 23,085 information calls during 1997. Of these callers, 1,176 spoke to an InfoLine attendant and asked specific HIV/AIDS/STD-related questions. Of the 1,167 callers who spoke to an operator, 44 percent were male; 45 percent were female, and 11 percent were unidentified. Of all the callers, three percent were Spanish-speaking.

- The Program Materials Review Panel (PMRP) met on November 20-21, 1997, in Austin, Texas. The PMRP consists of approximately ten members, representing each public health region. Members reviewed HIV, AIDS, and STD educational materials, including videos, pamphlets, and posters for distribution to the general public of Texas.

Future Plans

- Quality assurance reviews of HIV PCPE trainers will continue. In 1997, a Memorandum of Agreement was signed between TDH, the Texas Commission on Alcohol and Drug Abuse (TCADA), and the Texas Department of Mental Health and Mental Retardation (TXMHMR), which allows these collaborative agencies to use the TDH PCPE curriculum and have successful participant's names entered onto the TDH HIV Prevention Counselor Registry. Additional trainers will continue to be recruited statewide to assist in meeting the need for PCPE training.

- Final plans for the long term implementation of the cultural competence training curriculum will be completed.
- The TPEB will rewrite the CDC curriculum, *Assuring the Quality of HIV Prevention Counseling, A Workshop for Supervisors* and will begin teaching the course statewide.

- The Bureau of HIV and STD Prevention will coordinate the 11th Annual Texas HIV/STD Conference, scheduled for May 12-15, 1998, in Austin, Texas. At least 1,000 participants representing regional and local HIV and STD prevention and service agencies across the state are expected to attend.

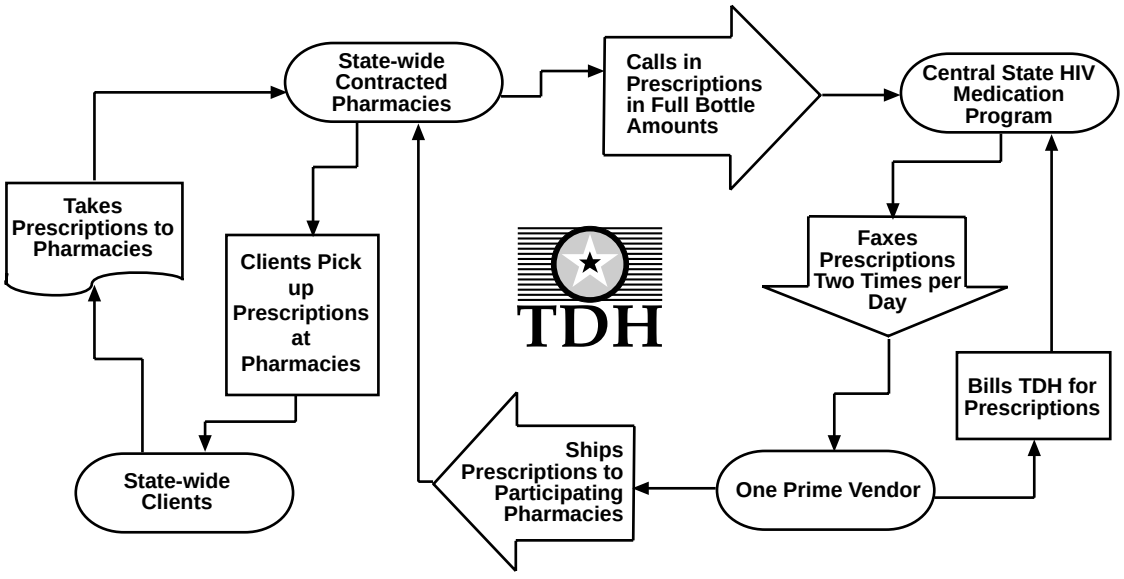
VIII. MEDICATION

HIV MEDICATION

The Texas HIV Medication Program provides medications to qualified HIV-infected individuals enrolled in the program from across the State. Working through 239 participating Texas pharmacies, the program purchases and distributes over $17 million annually in antiretroviral drugs and other prophylactic medications.

Since its inception in late 1987, the Medication Program has provided HIV medications to over 24,500 Texans. Currently, the program receives and approves more than 93,800 medication orders each year. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. Figure 13 shows how the program operates to ensure that qualified individuals anywhere in Texas have access to needed medications in a simple and timely manner.

Figure 13
Texas HIV Medication Program
Operation Process Flowchart



The program also develops and maintains confidential data files which provide valuable statistical information regarding medication usage to the Surveillance section of the HIV/STD Epidemiology Division, service providers and lawmakers. The program also collaborates with the Medicaid Vendor Drug Program to ensure optimum service delivery and avoid duplication of services. In order to maximize its medication purchasing flexibility and utilization of funds, the program developed and maintains its own accounting systems.

In addition to its regular services, the Medication Program operates the Medication Reimbursement Initiative (MRI). This program, formerly known as the Pilot Insurance Program, is operating in its fourth year of existence. The MRI program pays the deductibles and co-insurance payments required by the insurance companies of the Medication Program's approved clients, who then receive medications directly at their homes. The MRI program affords eligible HIV-infected persons the opportunity to use their insurance pharmacy benefits while keeping the state support costs to a minimum by utilizing private sector funds. Persons with insurance benefits that provide for prescription medications would otherwise be disqualified from receiving regular Medication Program services.

The Medication Program has contracted with Priority Pharmacy in San Diego, California to provide MRI medications. Priority Pharmacy has specialized in home delivery pharmacy services to HIV patients since 1987. To apply for MRI services, eligible applicants submit a completed regular Medication Program application and a completed client profile sheet with all the correct insurance information. Priority Pharmacy then verifies the applicant's prescription medication insurance benefits from this completed client profile. Priority Pharmacy also agrees to deliver the medications to each approved client by overnight mail at no cost to the approved applicant or the TDH. They also provide a toll-free number to all approved clients, their physicians, and the TDH for all communications relating to the approved applicant, their prescriptions, and access to an on-staff social worker.

Accomplishments

- The Medication Program approved 93,805 medication orders dispensed through participating pharmacies to nearly 6,730 individual clients.

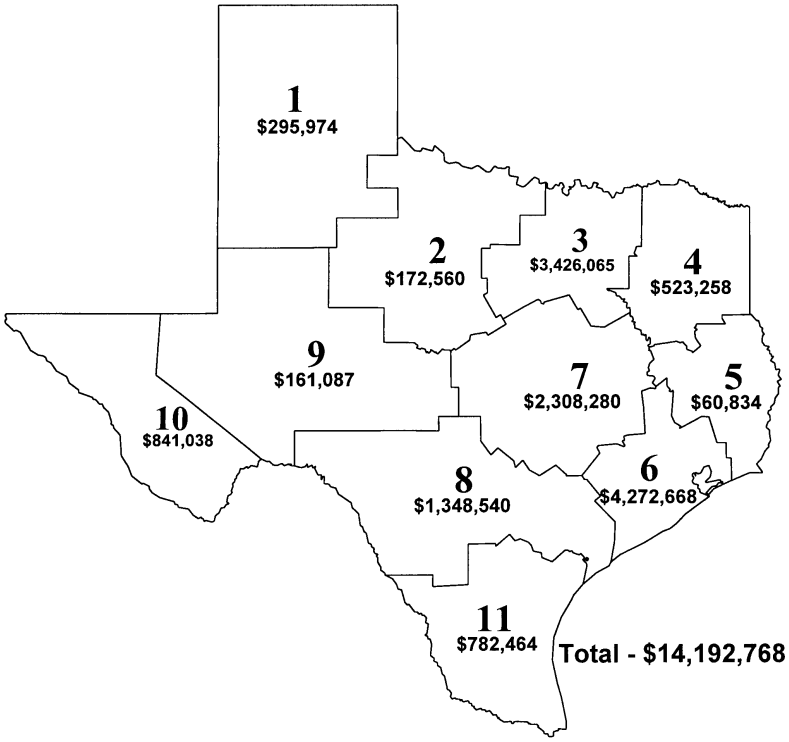
- The Medication Program added three new medications to the formulary, including the new class of non-nucleoside reverse transcriptase inhibitor medications.

- Thirty-one pharmacies joined the statewide network, providing greater convenience for clients and reducing client loads at individual pharmacies.

- For Fiscal Year 1997, the Medication Program paid MRI deductibles and co-insurance payments in the amount of $19,975. This total allowed approved applicants to access HIV-related medications at a total allowable cost of approximately $325,550. The MRI program served a total number of 39 approved applicants in Fiscal Year 1997.

- The Medication Program and the Medicaid Vendor Drug Program entered a joint arrangement in December of 1994 in which clients must fill their first three prescriptions each month using their Medicaid entitlement. Participating pharmacies will then contact the Medication Program for HIV-infected persons who need pharmacy assistance beyond the three-prescription-per-month Medicaid

Figure 14
HIV Medication Allocations by Region
Fiscal Year 1997



limit. The system has allowed clients to utilize both programs more effectively and ensures maximum utilization of the Medicaid program before TDH provides medication to Medicaid clients.

- The Medication Program began developing a new pilot program entitled Health Op*tions to Promote Employment (H.O.P.E.)* to assist persons with HIV in returning to work. To be eligible for the program, applicants must be Texas residents, HIV positive, and meet medical and income criteria. The overall expectation of the H.O.P.E. Program is that persons returning to the workforce will have the opportunity to either earn an income that would eliminate their need for Medication Program assistance or obtain health insurance benefits that sufficiently cover their prescription medications.

Future Plans

- The future standard of care will recommend that patients start on antiretroviral therapy with a combination of drugs earlier in the disease in order to preserve immune function. The Texas HIV Medication Program will continue to develop a system to accurately predict the growth of enrollees utilizing the program under these new treatment standards.

- In order to take full advantage of federal funding, the Texas HMP will protect Texas eligibility status and cooperate with national organizations collecting information to document state needs. The program will also explore private funding sources and redirect all appropriate funding streams to ensure access to standard of care therapy for Texans.

- The Texas HMP will develop clear clinical indicators in order to provide the new FDA-approved triple combination of antiretrovirals and protease inhibitors statewide.

- The Texas HMP will continue to refine the prioritization of the Medication Program drug formulary to be utilized in case of a potential funding shortfall.

STD MEDICATION

The Texas STD Medication Program distributed $561,538 in STD medications, needles, and protective needle adapters to 52 sites statewide in 1997. These sites include Public Health Region Offices, county health departments, and local health departments. These sites then deliver treatment directly to STD clients or supply the medications to the community providers who treat the clients.

Accomplishments

- The Texas STD Medication Program staff continued implementation of the new statewide medication distribution and inventory control systems. The new system reduces the number of direct shipment sites statewide and centralizes medication inventory control in the local health departments and regional offices. This system ties STD morbidity to actual medication allotment in an effort to encourage more timely and more accurate reporting of STDs statewide. This relationship is also intended to help the program set realistic stock levels of STD medications for each of its shipment sites, rather than relying on less exact estimates.

Future Plans

- The program plans to continue the new statewide distribution and inventory control system for all STD related medications. The program will, pending available funding, provide enough medication to treat a case and two contacts each for gonorrhea, chlamydia, syphilis, and pelvic inflammatory disease.

IX. HIV/STD CLINICAL SERVICES

The Clinical Services Section (CSS) consists of two programs, the Texas Medication Program and the Clinical/Case Management Program. The Texas Medication Program provides medications which are used to treat AIDS and to prevent opportunistic infections in individuals who have a clinical diagnosis of HIV disease, and meet drug specific eligibility criteria for the Program. The Clinical/Case Management Program monitors the quality of clinical/case management services provided to clients by 30 state funded grantees statewide. The Program conducts annual site reviews and periodic site visits, provides technical assistance when needed, develops minimum standards and clinical guidelines for the provision of clinical and case management standards, and conducts investigations of allegations of client abuse and neglect related to clinical/case management services.

Accomplishments

- The CSS continues to monitor all grantees annually, which has significantly improved the quality of the provision of clinical and case management services.

Future Plans

- The CSS will begin monitoring the quality of clinical and case management services provided by sub-contractors.
- The CSS is continuing to work with the network staff in the Bureau to establish a clinical/case management website which will have current information regarding treatment regimens and other related information about HIV/STD which will be available to contractors.
- In 1998 the CSS will assume responsibility for the Early Intervention Project. Pre-funding site reviews will be conducted at each of the applicant facility, and six will be awarded funds to provide early intervention services to clients with HIV disease.
- The CSS is in the process of hiring a nurse who will be headquartered in Region 2/3. This individual will assume responsibility for the grantees and their subcontractors in regions 1, 2/3 and 4.

X. APPENDIX

Texas AIDS Surveillance Report
October - December 1997
Summary of Cumulative Data

Table 1: Reported Chlamydia and Gonorrhea Cases

Table 2: Pelvic Inflammatory Disease and Chancroid

Table 3: Reported Syphilis Cases

Texas Department of Health
Bureau of HIV and STD Prevention
01/00